SUPPLEMENT

TO THE

BRITISH MEDICAL JOURNAL

LONDON: SATURDAY, APRIL 25th, 1936

CONTENTS

ANNUAL REPORT OF COUNCIL, 1935-6. *(For Contents see below)*

SPECIAL NOTICE TO MEMBERS

Every Member is requested to preserve this "Supplement," which contains matters specially referred to Divisions, until the subjects have been discussed by the Division to which he or she belongs. The Financial Statement will appear next week.

MATTERS REFERRED TO DIVISIONS

British Medical Association

ANNUAL REPORT OF COUNCIL, 1935-6

CONTENTS

PRELIMINARY

ANNUAL MEETING, OXFORD, 1936

The Annual Meeting, 1936, commences at Oxford on Friday, July 17th, under the presidency of Sir Farquhar Buzzard, Bt., K.C.V.O., LL.D., F.R.C.P.

ANNUAL MEETING, MELBOURNE, 1935

2. The scientific part of the 103rd Annual Meeting of the Association was held at Melbourne from September 11th to September 14th, 1935, under the presidency of Sir James Barrett, K.B.E., C.B., C.M.G., LL.D., M.Ch., F.R.C.S. Details of the meeting and of the World Tour in connexion therewith have already been published in the columns of the *British Medical Journal*.

The Council has had pleasure in conveying the thanks of the Association to the President (Sir James Barrett); the Honorary Local General Secretary (Dr. J. P. Major); the Honorary Local Treasurer (Mr. Edgar H. Ward); and the municipal and civic authorities and other local personages in Melbourne who contributed to the welfare and enjoyment of the members of the Association attending at Melbourne during the Meeting. The thanks of the Association have also been conveyed to the medical and civic personages and authorities of the various places at which official visits were made during the Tour.

ANNUAL MEETING, BELFAST, 1937—ELECTION OF PRESIDENT, 1937–8

3. In connexion with the Annual Meeting to be held in Belfast in 1937, the Northern Ireland Branch has nominated Professor R. J. Johnstone as President of the Association, 1937–8.

The Council recommends:

Recommendation: That Professor R. J. Johnstone, F.R.C.S.Eng., F.C.O.G., Professor of Gynaecology, Queen's University, Belfast; Gynaecologist, Royal Victoria Infirmary, Belfast; Consulting Surgeon, Belfast Maternity Hospital; member of Ulster Parliament, be elected President of the Association, 1937–8.

ANNUAL MEETING, 1941

4. The Council has accepted the invitation of the Federal Council of the Medical Association of South Africa to hold the Annual Meeting of the British Medical Association in 1941 in South Africa.

DEATH OF KING GEORGE V

5. The following letter of condolence was addressed to King Edward VIII and the Royal Family upon the occasion of the death of King George V, to which the following acknowledgment was received:

"TO THE KING'S MOST EXCELLENT MAJESTY.

The Humble Address of the President and Members of the British Medical Association.

MAY IT PLEASE YOUR MAJESTY,

We, Your Majesty's dutiful and loyal subjects, the members of the British Medical Association, distributed throughout Your Majesty's Empire, beg leave to express our respectful and heartfelt sorrow at the heavy affliction that has fallen upon Your Majesty, The Queen Mother, and the other Members of the Royal Family, by the death of our beloved Sovereign King George, Patron of the Association.

We humbly tender to Your Majesty congratulations upon Your Accession to the Throne, and earnestly pray that Your Majesty's Reign may be long and illustrious and blest with peace.

Signed on behalf of the
British Medical Association,

Humphry Rolleston,
President (*Acting*).

E. Kaye Le Fleming,
Chairman of Council.

H. S. Souttar,
Chairman of Representative Body.

N. Bishop Harman,
Treasurer.

G. C. Anderson,
Medical Secretary."

Home Office,
Whitehall.
March 17th, 1936.

SIR,

I have had the honour to lay before The King the Loyal and Dutiful Address of the British Medical Association on the occasion of the lamented death of His late Majesty King George the Fifth and have received the King's commands to convey to you His Majesty's grateful Thanks for the assurances of sympathy and devotion to which it gives expression.

I am, Sir,
Your obedient Servant,
(Sgd.) JOHN SIMON.

The Medical Secretary,
British Medical Association House.

OBITUARY

6. The Association deplores the loss of the following members:—

Lieut.-Colonel HUGH WM. ACTON, I.M.S. Member, Calcutta Branch Council. Vice-President, Section of Tropical Medicine, 1932.

Mr. EMMANUEL CAETAN ALLES. President, Ceylon Branch.

Professor JOHN ANDERSON. President, Dundee Branch. Member, Scottish Consultant and Specialist Group Committee.

Dr. WM. BUCHAN ARMSTRONG. Chairman, Dumbartonshire Division.

Dr. ROBERT ARTHUR ASKINS. Chairman and Representative, Bristol Division.

Dr. HENRY JOHN BANKS-DAVIS. Secretary, Section of Laryngology, 1910.

Dr. MOSES GEORGE BIGGS. Member of Council. President, Metropolitan Counties Branch. Chairman and Representative, Wandsworth Division. Chairman, Central Ethical Committee.

Dr. HENRY DRAPER BISHOP. Representative, Guernsey and Alderney Division.

Professor WM. BLAIR-BELL. Secretary, 1910, Vice-President, 1923, Section of Gynaecology and Obstetrics.

Dr. ADOLPH BRONNER. Member of Council. Secretary, 1889, Vice-President, 1893, Section of Otology.

Dr. JOHN RIDLEY BURNETT. President, Border Counties Branch.

Mr. HENRY JOHNSTONE CAMPBELL. Member of Council. Chairman and Representative, Torquay Division. Member, Science and Hospitals Committees. Vice-President, Section of Pharmacology and Therapeutics, 1912.

Dr. RONALD GEORGE CANTI. Secretary, Section of Pathology and Bacteriology, 1926. Vice-President, Section of Pathology and Biochemistry, 1931.

Dr. EDWIN ALBERT CHILL. Representative, West Middlesex Division.

Dr. JERRY EWING CHOW. Secretary, British Guiana Branch.

Dr. SIDNEY HERBERT CLARKE. President, Hertfordshire Branch. Chairman and Representative, St. Albans Division. Secretary, Section of Psychological Medicine, 1909.

Dr. DIXIE PAUMIER CLEMENT. President, Western Australian Branch.

Dr. WM. COLLIER. President of the Association. Member of Council. Secretary, Oxford and Reading Branch. Chairman and Representative, Oxford Division. Secretary, Section of Medicine, 1895.

Dr. HAROLD MARTIN MCCULLOCH COOMBS. Chairman, Bedfordshire Division.

Dr. FRANK CHETWODE CRAWLEY. President, Section of Ophthalmology, 1933.

Dr. SAMUEL GEORGE DAVIDSON. Member, South-Eastern Counties Division Executive Committee.

Surgeon Rear-Admiral HERBERT WM. GIBBS DOYNE. Secretary, Section of Navy, Army, and Ambulance, 1904.

Dr. WM. CRAN DUTHIE. Chairman, Blackburn Division.

Dr. JOHN JAMES EDGAR. Chairman, Hawkes Bay Division.

Dr. JOHN TRIMBLE ELLIOTT. Secretary, Monaghan and Cavan Branch.

Dr. STEWART FARQUHARSON. Secretary, Chelsea Division.

Dr. STEPHEN GEORGE FLOYD. Chairman, South Essex Division.

Dr. DAVID HAMMAND FRASER. Chairman, Hampstead Division. Member, Non-Panel Committee.

Dr. ROBERT GOURLAY. Representative, Oldham Division.

Dr. JOHN WALLACE GRAHAM. Representative, Tanganyika Branch.

Lieut.-Colonel CHARLES GRAHAM GRANT. Vice-President, Section of Forensic Medicine, 1932.

Dr. ALBERT ALEXANDER GRAY. Vice-President, 1910, President, 1922, Section of Otology. Vice-President, Section of Laryngology, Rhinology, and Otology, 1914.

Dr. JOHN GILCHRIST GRAY. Representative, Glasgow North-Western Division.

Dr. JOHN RICHARD GRIFFITH. Chairman, Monmouthshire Division.

Mr. WM. LAYARD GRIFFITHS. Chairman, Swansea Division.

Dr. HENRY CHARLES HEATHCOTE. Chairman, Bath Division.

Dr. ROBERT HENRY. Chairman, Belfast Division.

Dr. WM. EDWARD HOME. Member, Health of Merchant Seamen Subcommittee.

Dr. ROBERT EDWARD HOWELL. President, North of England Branch. Chairman and Representative, Cleveland Division. Vice-President, Section of Radiology and Electrotherapeutics, 1921.

Dr. ALGERNON FITZ-ROY HUGHES. President, Secretary, and Representative, Grenada Branch.

Dr. JOHN HUME. Secretary and Representative, Perth Branch. Member, Scottish Committee.

Dr. JOSEPH HUNTER. Chairman, Secretary, and Representative, Dumfries and Galloway Division. Member, Scottish Committee.

Dr. WM. HOWARD JONES. Vice-President, Section of Anaesthetics, 1934.

Dr. JOHN PATRICK DAUNT LEAHY. President, New Zealand Branch.

Dr. ALFRED AUSTIN LENDON. Representative, South Australian Branch.

Mr. ERNEST MUIRHEAD LITTLE. Vice-President, Section of Diseases of Children, 1914. Vice-President, 1925, President, 1926, Section of Orthopaedics.

Dr. DAN MCKENZIE. Vice-President, Section of Oto-Rhino-Laryngology, 1921. Vice-President, Section of Oto-Laryngology, 1932.

Dr. GEORGE DOUGLAS MATHEWSON. Secretary, Section of Medicine, 1927.

Lieut.-Colonel ROBERT HERBERT MILLS-ROBERTS. President, North Wales Branch.

Dr. RICHARD JOHN MORRIS. Chairman, Harrogate Division.

Dr. ROBERT NESBITT. Chairman and Representative, Nottingham Division.

Dr. GEOFFREY ALEXANDER AMHERST ORLEBAR. Representative, Brighton Division.

Dr. ALBERT HAROLD OWEN. President, Tanganyika Branch.

Dr. RICHARD OWEN. President, North Wales Branch. Chairman, North Caernarvon and Anglesey Division.
Dr. NASARWANJI NOWROJI PARAKH. President, Burma Branch.
Dr. JAMES WESLEY PEATT. Chairman, Belfast Division.
Dr. SEPTIMUS TRISTRAM PRUEN. Honorary Local Secretary, Cheltenham Meeting, 1901. President, Gloucestershire Branch.
Dr. LEWIS WM. REYNOLDS. President, South Midland Branch.
Dr. DAVID RICE. President, Norfolk Branch. Chairman and Representative, East Norfolk Division.
Mr. CHARLES ROBERTS. Vice-President, Section of Surgery, 1929.
Dr. ROBERT ROWLANDS. Chairman, South Caernarvon and Merioneth Division.
Dr. DAVID ROXBURGH. Chairman and Representative, Marylebone Division. Member, Committee *re* Lunacy Law and Mental Disorders.
Dr. NELSON CAMERON SCLATER. Chairman, Birkenhead Division.
Dr. WM. SINCLAIR. President, Aberdeen Branch.
Dr. JOHN LINDSAY SPEIRS. President, North of England Branch. Chairman and Representative, Gateshead-on-Tyne Division.
Mr. WM. THOMAS HOLMES SPICER. Secretary, 1895, Vice-President, 1902, Section of Ophthalmology.
Mr. WM. STEWART. President, Edinburgh Branch. Representative, Edinburgh and Leith Division.
Dr. CHARLES THOMPSON. Chairman, Mid-Staffordshire Division.
Dr. JOHN HOLMES THOMPSON. Chairman and Representative, Nottingham Division.
Colonel FREDERIC HIBBERT WESTMACOTT. Member, Arrangements Committee. Secretary, 1902, Vice-President, 1910, Section of Otology. President, Section of Oto-Rhino-Laryngology, 1929.
Dr. ANDREW YOUNG. Representative, Ayrshire Division.

Mr. Andrew Blair Aitken, Dr. Maria Shepherd Allen, Dr. John Westall Anderton, Dr. Arthur James Arch, Dr. Stanley Noel Babington, Dr. John Burder Backhouse, Dr. Frederick Barnes, Dr. Denis Francis Barrett, Dr. Robert Hasby Barrett, Surgeon Capt. Henry Bullen Beatty, Dr. Henry Edward Belcher, Dr. Charles Bennett, Dr. George Herbert Bennett, Major Joseph Godfrey Bird, I.M.S., Dr. David Blackley, Dr. Percival James Bodington, Dr. Frederick Stanley Booth, Mr. Thomas Hugh Boyd, Dr. Augusto Braccer, Dr. Norman Braithwaite, Dr. Wm. Adam Brechin, Dr. John Macdonald Brown, Dr. Thomas Gerard Brown, Dr. Wm. Murdoch Buchanan, Dr. Edward Wm. Buckley, Dr. John Stewart Caldwell, Dr. Wallace Harry Charles Candler, Dr. Denny Edward Cantillon, Dr. Hubert Cecil Carden, Dr. Louis Leonard Carlos, Dr. Daniel George Carmichael, Dr. Wm. John Carmichael, Surg. Vice-Admiral Sir Joseph Chambers, Dr. Florence Stacey Cleminson, Dr. Patrick John Collins, Dr. Thomas Edward Constant, Dr. Thomas Goodall Copestake, Dr. Henrique Adolfo Cottin, Dr. Robert Hugh Cotton, Dr. Thomas Reginald Couldrey, Surgeon Capt. John Wm. Craig, Dr. Robert Henry Craig, Dr. Paul Alfred Creux, Dr. Thomas Cromie, Lieut.-Colonel Robert Davidson, R.A.M.C., Dr. Walter Leslie Davies, Dr. Archibald Alexander George Dickey, Dr. James Smith Donaldson, Lieut.-Colonel James Dorgan, Dr. Douglas Dixon Dryden, Dr. Wm. Arthur Durance, Dr. John Edmondson, Dr. Griffith Evans, Dr. Gilbert John Farie, Dr. Richard Vernon Favell, Dr. George Hammond Field, Dr. Walter Harington Fisher, Dr. Wm. Fletcher-Barrett, Dr. John Williams Ford, Dr. Samuel Walker Foster, Dr. Wm. Campos Fragoso, Dr. Jacob Freud, Dr. Andrew Fuller, Dr. Norman Evan George, Dr. Stanley Rider Gibbs, Lieut. John Monro Gibson, R.A.M.C., Dr. Vaman Gopal Gokhale, Dr. Joseph Ernest Good, Dr. Nathaniel Grace, Dr. John George Grant, Dr. Frederick Wm. Marshall Greaves, Dr. Philip Anthony Mark Green, Dr. John Temperley Grey, Dr. Henry Habgood, Dr. George Hall, Dr. Alexander Mein Hardie, Dr. Henry Leeds Harrison, Dr. Archippus Harry, Dr. George Hern, Dr. James Preston Hocken, Dr. Wm. John Hogg, Dr. Lily Holt-McCrimmon, Dr. Samuel Henry Hughes, Dr. Dirk de Vos Hugo, Dr. Wm. Carr Humphreys, Dr. Smeeton Johnson, Dr. John Wm. Johnston, Dr. Edwin Evanson Jones, Dr. Valentine Llewellyn Watson Jones, Dr. George Wm. Joseph, Dr. Leila Kathleen Keatinge, Dr. Orme Stirling Kellett, Dr. John Wm. Kennedy, Dr. Thomas James Whitney Keown, Dr. Edward Kingsbury, Dr. Arthur Lee, Dr. Priestley Leech, Dr. Arthur Cedric Lewis, Major Joseph Pearson Little, R.A.M.C., Dr. Joseph S. Love, Dr. John Knowles Lund, Dr. Cyril Reginald Lunn, Dr. Harold Guthrie McAllum, Dr. Cecil Wm. Roberts McCaldin, Dr. Thomas McCrae, Dr. John Henry Raymond McCutcheon, Dr. George Godfrey Macdonald, Dr. Wm. Fraser Macdonald, Dr. John Alexander Macfarlane, Dr. Kenneth Walter Ingleby MacKenzie, Dr. Donald Gordon Stewart McLachlan, Dr. Samuel McLean, Dr. Wm. Bernera Macleod, Dr. Archibald Cotterell McMaster, Dr. John McMichael, Dr. James Campbell MacNeillie, Dr. Cletus McShane, Dr. Colin McVicar, Dr. Gilbert Marshall, Dr. Albert Ernest Marwood, Dr. Gladys Matthews, Dr. Charles Booth Meller, Dr. David John Micah, Dr. Arthur Alan Miller, Dr. Edward Pigott Minett, Dr. John Joseph Minihan, Dr. David Duke Monro, Dr. Idris Naunton Morgan, Dr. George Herbert Morrison, Dr. John Hall Morton, Dr. Basil Eustace Moss, Dr. George Harold Mounsey, Dr. A. N. Mukerji, Dr. Daniel Mulcahy, Dr. Walter Francis Murphy, Dr. Walter Gifford Nash, Dr. Charles Nelson, Dr. Joseph O'Brien, Dr. Francis Martin O'Donoghue, Dr. Laurence Lindley Pollock Paterson, Dr. James Williamson Patrick, Dr. Alfred Cyril Pedler, Dr. Samuel Edward Pedley, Mr. Walter Sydney Perrin, Dr. Samuel Ernest Picken, Dr. Pieter Jacobus Johannes Pienaar, Dr. Arthur John Scott Pinchin, Dr. Charles Planck, Dr. Herbert John Plowright, Dr. Labbhu Ram, Dr. Paras Ram, Dr. Leonard Redmond, Dr. James Reid, Dr. Robert Christie Reid, Dr. Jeremiah Reidy, Mr. Arthur Haden Richardson, Dr. Edward Roberts, Dr. Katherine Octavia Robertson, Dr. Joseph Robinson, Dr. Edwin Ernest Wm. Roe, Dr. John King Roger, Dr. Renzo Rosati, Dr. Wm. Livingston Ross, Dr. James Lougheed Rowlett, Dr. Edward Leopold Rowse, Dr. Charles Frederic Rumboll, Major Behram Pestonjee Sabawala, Dr. Wilmot Samarasinghe, Dr. Geoffrey Easton Scott, Dr. Robert Cowan Scott, Dr. Wm. Webb Shackleton, Dr. Abdul Majid Shah, Dr. Ebenezer Shaw, Major Frederick Roland Studdert Shaw, Dr. John Shaw, Dr. Amy Sheppard, Dr. Joseph Sillars, Dr. Andrews Mackenzie Ross Sinclair, Dr. Julienne Singham, Dr. Wilfred Leslie Sleight, Dr. James Livie Smith, Dr. Surtees Smith, Dr. John Joseph Stanley, Dr. George Frederick Stericker, Dr. James Stewart, Mr. Wm. Stuart-Low, Dr. A. V. Subramania-Aiyer, Dr. Ian Dishart Suttie, Dr. Arthur Swain, Dr. Nicholas Daunt Sweetnam, Dr. Edward Tate, Dr. Charles Carlyle Tatham, Dr. Charles Henry Shinglewood Taylor, Dr. Richard Waring Taylor, Dr. John Tehan, Dr. Sydney Wilson Thompstone, Dr. Wm. Thomson, Dr. Johnstone Simon Thwaites, Dr. Wm. George Herbert Tregear, Dr. Donald Rupert Charles Tregonning, Dr. Nigel Alan Allison Trenow, Dr. Joseph Henry Ensor Trout, Dr. Wm. Robert Elstob Unthank, Dr. Paul Johannes Van Coller, Dr. K. V. Veerasingam, Dr. Archibald Hutton Veitch, Dr. Ethel Miller Vernon, Dr. Hugh Walker, Dr. Hygeia Leigh Josephine Wallace, Dr. George Richard Simon Walles, Lieut.-Colonel Lloyd Brereton Ward, Dr. Alexander Waugh, Dr. Laurence Craigie Maclagan Wedderburn, Dr. David Westwood, Dr. Christopher Urry Wickham, Dr. Erroll Holdsworth Williams, Dr. Alfred Wills, The Rev. Horace Bagster Wilson, Dr. James Alexander Wilson, Dr. Wm. Alexander Wilson, Dr. Heinrich Wohlgemuth, Dr. Annette Kathleen Wood-Martin, Dr. Bernard Duncan Zorapore Wright, Dr. John Matthew Wrigley, Dr. David Thomas Wylie, Dr. Wm. Robertson Wylie, Dr. George Yeoman, Dr. George Young.

KING EDWARD VIII AS PATRON OF THE ASSOCIATION

7. The Council is proud to report that His Majesty King Edward VIII has been graciously pleased to grant his Patronage to the Association.

INTERDEPARTMENTAL COMMITTEE ON ACCIDENT INCAPACITY

8. The report of the Association's Fractures Committee has resulted in the appointment by the Government of an Interdepartmental Committee to inquire into the arrangements at present in operation with a view to the restoration of the working capacity of persons injured by accident and to report as to what improvements or developments are desirable and what steps are expedient to give effect thereto, regard being had to the recommendations made in the report issued by the British Medical Association in February, 1935, on " Fractures."

GIFTS TO THE ASSOCIATION

9. The Council has pleasure in reporting the following gifts to the Association:

By Miss Bennett, a portrait of her father, the late Sir James Risdon Bennett (one-time President of the Royal College of Physicians) ;

By the Isle of Man Branch, an example of the Manx Flag to be hung in the Great Hall ;

By Dr. C. E. Douglas (St. Andrews), a B.M.A. Chess Challenge Cup, to be known as " The Melbourne Cup " ;

By Mr. W. McAdam Eccles (London), a photograph of two old men playing chess, entitled " Checkmate " ;

By the City of Melbourne, an example of the City of Melbourne Flag, to be hung in the Great Hall to commemorate the Annual Meeting, Melbourne, 1935.

Nomination of Dr. Arnold Lyndon as a Vice-President

10. The Council recommends:

Recommendation: That Arnold Lyndon, O.B.E., M.D., be elected a Vice-President of the Association under Article 41 and By-law 77 in recognition of the valuable service he has for many years rendered to the Association and to the medical profession.

Representation on Outside Bodies

11. During the session the following appointments and reappointments have been made by the Council:

Central Council for District Nursing in London: Sir Comyns Berkeley, Dr. W. Paterson, and Dr. Mary Blair; National Smoke Abatement Society: Mr. N. Bishop Harman and Dr. G. C. Trotter; Council of Epsom College: Dr. A. Lyndon; Court of Governors of London School of Hygiene and Tropical Medicine: Sir Henry Brackenbury; Dangerous Drugs Tribunal, England: Dr. J. W. Bone; Dangerous Drugs Tribunal, Scotland: Dr. T. K. Monro; Association Professionnelle Internationale des Médecins: Dr. G. C. Anderson; National Florence Nightingale Memorial Committee: Dr. E. W. G. Masterman; Association of British Health Resorts: Dr. E. Kaye Le Fleming and Dr. C. W. Buckley: Central Council of Recreative Physical Training: Dr. E. Kaye Le Fleming; Council of Chartered Society of Massage and Medical Gymnastics: Dr. C. Hill; International Hospital Association: Dr. P. Macdonald; Inter-Departmental Committee on Restoration of Working Capacity of Persons Injured by Accidents: Mr. H. S. Souttar; British National Human Hereditary Committee: Dr. R. J. A. Berry.

Delegates of the Association to Conferences of Outside Bodies

12. During the session the following members have been appointed delegates to represent the Association at the conferences indicated:

Fourth biennial Mental Health Congress: Dr. R. G. Gordon and Professor R. J. A. Berry; National Smoke Abatement Society Conference: Dr. G. M. FitzGibbon; Conference of Representatives of Physical Training, etc., Organizations: the Assistant Medical Secretary (Dr. A. Macrae); Royal Sanitary Institute Congress, Southport: Dr. H. J. Milligan; Canadian Medical Association Annual Meeting, 1936: Dr. W. Harvey Smith; National Association for the Prevention of Tuberculosis Conference: Sir Robert Philip; National Conference on Maternity and Child Welfare: Dr. W. H. F. Oxley; Smoke Abatement Conference: The Treasurer and Dr. G. C. Trotter; American Medical Association, 1936 Meeting: Lord Horder.

Association Professionnelle Internationale des Médicins

13. The Council in submitting the following report of the Association's Correspondent (Dr. Alfred Cox) on the tenth Annual Conference of the above-mentioned body feels sure that members of the Association will approve of its action in expressing appreciation of the great services which Dr. Cox has rendered the Association as its Correspondent for the past ten years:

The conference for 1935 was held in Brussels in September last in one of the conference halls of the International Exhibition. The president was Professor Tornel, representative of Spain, and the following countries were represented: Belgium, Bulgaria, Denmark, Estonia, France, Germany, Great Britain, Greece, Holland, Hungary, Luxembourg, Norway, Poland, Sweden, Switzerland, and Yugoslavia. Austria was again absent because of financial difficulties, but we were encouraged by the news that Italy has now definitely signified its adhesion to the A.P.I.M., and that some of the South American countries whose interest has hitherto been of a platonic nature are likely to take a more active part. Invitations for the next conference were received from Denmark, Hungary, and Holland, and it was decided to accept the Dutch invitation for Amsterdam in September, 1936. The president will be Dr. Mattlet of Belgium.

The financial statement showed that in the face of great difficulties the A.P.I.M. is holding its own, and has a small credit balance.

It will interest those who remember what I have previously said about the acute Hungarian medical situation, to hear that Dr. de Csillery, the representative of that country, a member of Parliament, and a former Minister of Health, told us that the situation there, though still difficult, had been considerably alleviated by the action of the A.P.I.M. After our meeting in Paris in 1935 I wrote a letter to our *Journal* (and several other representatives took similar action in their own countries) expressing surprise that a supposedly civilized country like Hungary should attempt to victimize the members of the Hungarian Medical Association, and indeed to crush that body. Dr. de Csillery reported that the *British Medical Journal* containing my letter had been brought to the attention of the Minister, who did not like it, but the fact that the Hungarian situation was receiving unfavourable attention from the outside world had undoubtedly had considerable effect in modifying a situation which, though still unsettled, is now more favourable to the profession.

The Work of the Conference

The work of the conference consisted mainly in the discussion of the answers to the questionnaires sent out during the year, which, as always, gave a very informative conspectus of the views of the profession in the different countries on the questions submitted to them. And, as always, the discussions showed that in spite of considerable differences in national professional customs there is no real difference in essentials.

The questionnaires were three—namely, (1) on the legal rights and duties of the profession *vis-à-vis* their Governments; (2) on the possibility of formulating a medical charter; (3) on medical publicity.

In addition, information had been demanded (1) by Hungary as to the number of medical members of Parliament; (2) by Denmark, as to whether there was any special system of insurance for radiologists against the risks incurred by them; and (3) by Belgium, as to whether naval and military doctors were allowed to practise privately. These questions were answered promptly by the national correspondents and the information sent to the querists. The secretary reported a considerable growth in the correspondence addressed to him by outside bodies. The treasurer, in accordance with the traditions of his office, wanted to save money by curtailing the number of questionnaires, but the conference would have none of it, realizing that their issue is one of the chief *raisons d'être* of the A.P.I.M.

The Legal Rights and Duties of Doctors

On this we had a long and detailed report from the rapporteur, Dr. Luuk of Estonia, and a very interesting discussion, which disclosed, among other things, the anxiety of the French profession to diminish the influx of foreign doctors who have swarmed into France since the war. I found myself at variance on one point with most of my colleagues, who thought that when collective contracts had been established the Government ought to enforce them even if the Government had had no voice in their establishment. As usual, I had difficulty in making clear the distinction between the General Medical Council and the British Medical Association. Our foreign colleagues persist, like the Press in this country, in regarding the B.M.A. as the all-powerful body. This is flattering, but I had, reluctantly, to undeceive them.

A Medical Charter

This produced an excellent and absorbing discussion. The Continental mind is much more inclined than ours to desire to formulate and define things which we in this country prefer to leave indefinite. The Latin mind despairs of our *solvitur ambulando* methods, but it has to agree, somewhat reluctantly, that they *work*. Though I told the conference that the profession in this country was not likely to formulate or adopt a charter, it was not difficult for any of us to subscribe to the statement finally agreed, based as it was on the Hippocratic Oath. Much discussion occurred on the question of medical secrecy, and the French representative was, as always, very rigid on this point. Our method of stating the name of the disease on national health insurance certificates is regarded, more in sorrow than in anger, as an ingenious but illogical artifice only to be explained by the obstinate British love of compromise. The charter, which appears in full in the *Revue Internationale* for November, 1935, is well worth study, and several of my colleagues believe that it is a document which will be of considerable value to their bodies as a succinct statement of the fundamental principles for which the medical profession stands. There was only one item in it with which I could not agree—namely, the expression of belief in the payment per attendance for *all* medical services. Having in mind our experience, I had to record my dissent, so far as contract practice is concerned.

Medical Publicity

In this discussion we found ourselves confronted by a steady growth of undesirable lay publicity in medical affairs in every country. Our own seems to have been comparatively lucky so far. Publicity inspired by doctors themselves is unanimously disapproved by every medical organization, and some Governments, nominally, punish it severely. But, helped by a Press permeated with ideas derived mainly from the other side of the Atlantic, the evil continues to grow everywhere. The conference arrived unanimously at certain conclusions, which can be summarized as follows:

(1) It is necessary in every country that the disciplinary medical authority should take a strict view of its responsibilities in this matter.

(2) There ought to be a Government Commission in every country, consisting of representatives of the Government, of the various medical and pharmaceutical bodies interested, and of the responsible lay press, to control all such publicity.

It is a pleasure to report that my statement as to the steps taken by the B.M.A. to interest and enlist the support of the Press in the matter of exaggerated and misleading advertisements of alleged " cures " was welcomed by the conference as being new, interesting, and useful. Nothing comparable seems to have been done elsewhere.

Programme for 1936

Questionnaires on (1) hospital administration, (2) voluntary medical insurance for the middle classes, (3) the repercussion of national health insurance on the ordinary practice of medicine. In addition, two short questions: (1) How does the system of first aid for road accidents function? ; and (2) the respective functions of State and voluntary medical professional organizations—for example, General Medical Council and British Medical Association.

Finally, I have to lay down my office as representative of the B.M.A., and to wish my successor as much pleasure and profit from it as I have had. Amongst many privileges which the Association has granted me during my long connexion with it, there are very few I would rate higher than the opportunity given to me to meet, and to learn from, my colleagues in the other great national medical associations. I gained much, and what I learned found its way directly and indirectly into my work in and for the B.M.A. And I am glad to believe, from what my foreign colleagues have often told me, that the information I was able to impart from my B.M.A. experience has been found useful to others. Thus ends another chapter in my happy B.M.A. life.

PRESENTATION OF THE GOLD MEDAL OF THE ASSOCIATION TO DR. H. G. DAIN

14. The Council decided to present the Gold Medal of the Association to Dr. H. G. Dain in recognition of his distinguished work in connexion with the administration of medical benefit under the National Health Insurance Acts and the outstanding services he has rendered to the Association. Dr. Dain (Deputy Chairman of the Representative Body) is best known for the great work he has done on behalf of insurance practitioners and the Association during the eleven years 1924–35, when he occupied the Chair of the Insurance Acts Committee of the Association. The Council feels sure that the Association will agree with its view that there could not be a more worthy recipient of the highest honour which the Association can confer.

NUTRITION

15. The Council reported to the Representative Body in 1935 its intention to publish a Supplementary Report on Nutrition, consisting of a practical application of the most appropriate data set out in the Nutrition Report, which the Association published in November, 1933, and of which some 50,000 copies were sold.

The new publication, entitled " Family Meals and Catering," was published in an attractive form in September, 1935, and over 100,000 copies have been sold.

MEDICAL SECRETARIAT

16. In November, 1935, Dr. A. D. Macpherson, Assistant Medical Secretary, retired under the age limit. Dr. R. W. Durand took up his position as Assistant Medical Secretary the same month.

The Council regrets to announce the deaths in March, 1936, of Sir James Smith Whitaker, the first Medical Secretary of the Association (1902–12), and in January, 1936, of Dr. T. Hennessy, Irish Medical Secretary from 1914 to 1936.

COUNCIL DINNER

17. For many reasons it was not possible to hold the Council Dinner in the autumn of 1935, but arrangements are being made for this function to take place on the evening before the Council meeting in November next.

COUNCIL ATTENDANCES

18. A list of attendances at meetings of the Council from the A.R.M., 1935, to April, 1936, will be found in Appendix I.

FINANCE

19. At various places in the Report of the Council will be found references to activities of the Association which have involved expenditure, sometimes of an unusual and heavy nature. The Council is happy to report that not only have these expenses been met but the large loans which were necessary for the completion of the first sections of the Association's House have been practically repaid, and the financial prospects for dealing with the further extensions for which the Association has contracted are more favourable than appeared likely during the period known as the " depression."

Balance Sheet

20. The Balance Sheet (Appendix II, *to appear in Supplement of May 2nd*) shows this year an unusual feature: the Metropolitan Counties Branch stands as a creditor for £505 13s. This is the result of an arrangement whereby the capitation grants and the balance of the Branch Accounts are now credited to the M.C.B. in the Association's Books and payments made thereout on the instructions of the Branch Treasurer: the effect has been to save overdraft interest on a portion of the Association's indebtedness.

The overdraft at the bank has been reduced by nearly £10,000.

After making all adequate reserve provisions as approved by the Council in previous years, the sum of £1,969 8s. 10d. has been added to the Surplus Account.

The premises of the Association, leasehold in London and held by feu-charter in Edinburgh, stand together at a value of £272,259.

The Sinking Fund Policies, taken out to provide eventually a sum of £200,000 towards the redemption of the Association's property, stand at the substantial figure of £13,553.

Subscription Arrears.—The loyalty with which members pay their annual subscriptions and the efficiency of the machinery for collection are demonstrated by the comparatively small amount coming under this heading. The number of arrears outstanding at December 1st, 1935, was 2,417 (on a membership of 35,383) as against 2,288 at the end of 1934. The item £3,937 is known to be represented partly by subscriptions of over-seas members, which may have been paid to Branch secretaries abroad but have not been advised to us or reached the Head Office before the close of the year.

The Reserve for Bad Debts and Discounts in respect of Advertisements is considered to be sufficient, the loss from this source during recent years being very small indeed.

Income and Expenditure Account

The income for the last three years has been as follows:

	£	s.	d.
1933	156,007	9	3
1934	154,821	3	0
1935	160,090	6	4

The expenditure for the same period was:

1933	153,166	18	11
1934	152,277	17	0
1935	158,121	18	0

so that after making transfers to the Sinking Fund and Reserve Accounts to comply with decisions previously arrived at and also providing the agreed annual sum towards the commitments for extension of premises, a net sum (in the books) of £1,968 has been transferred to the Surplus Account.

Subscriptions.—The membership of the Association on December 31st, 1935, was 35,383, an increase on the year of 354.

The subscription income for 1935 increased by £361 3s. 7d., but the amounts recovered from former years decreased by £147 6s. 8d.

The Association is aware that not all the sums carried forward in the accounts as "Subscriptions in Arrear" are lost.

The Balance Sheet of December 31st, 1933, included such a sum of £3,898 13s. 9d., of which no less than £3,364 11s. 3d. was recovered during 1934. The balance of £534 2s. 6d. was included in the amount of £4,215 8s. 9d. written off in the Income and Expenditure Account of December 31st, 1934.

A further sum was received during 1935 which, together with amounts collected by the Head Office in respect of 1934 subscriptions written off and the amounts received in respect of previous years' subscriptions, make a further recovery during 1935 of 1,060 subscriptions representing £2,746 7s. 3d., as shown in the Income and Expenditure Account.

Similarly, out of the sum of £3,709 5s. 5d. carried forward in the Balance Sheet of December 31st, 1934, no less than £3,267 0s. 8d. was recovered during 1935, leaving outstanding only the sum of £442 5s. 3d.

Rents Received and Accrued.—It is pleasant to be able to report that there is a certain amount of demand arising for office accommodation, and additional subleases are being granted to tenants.

Interest on Investments.—The increase is accounted for by the investment in 3 per cent. Local Loan Stock, and a further bonus from the British Medical Bureau.

N.O.T.B.—It is gratifying to note the larger refund during 1935.

ABSTRACT A

21. The Revenue from Advertisements and Sundry Sales has been increased, that from advertisements by an increase in the number pages obtained, and that from sundry publications by the very great success of the Association's pamphlet "Family Meals and Catering." The substantial increase from £57,955 2s. to £62,319 6s. 6d. should be noted.

The following are the comparative figures of the pages:

	1934	*1935*
Literary and Epitome ...	2,628	2,848
Supplement	668	620
Advertisements	3,100	3,284
	6,396	6,752

Compositors' Wages, Machining, etc.—The costs charged under this heading are dependent not only upon the total number of pages and the total number of copies produced, but also to some extent upon the various "sizes" in which the weekly issues of the *Journal* must be made, and the amount of material which has to be set and corrected, used, or destroyed as "cancelled matter."

The weekly issues of the *Journal* were made up as follows:

	1934	*1935*
96 pages	1	
100 ,, ...	2	
104 ,, ...	3	2
108 ,, ...	2	3
112 ,, ...	6	1
116 ,, ...	3	3
120 ,, ...	8	7
124 ,, ...	8	4
128 ,, ...	7	5
132 ,, ...	6	6
136 ,, ...	1	7
140 ,, ...	1	4
144 ,, ...		5
148 ,, ...	1	2
152 ,, ...		1
156 ,, ...		2
160 ,, ...	2	
168 ,, ...	1	
	52	52

The number of pages increased from 6,396 to 6,752; the number of copies printed from 1,976,000 in 1934 to 1,989,250 in 1935.

Paper.—Further efforts were made by the paper merchants and agents to improve the opacity and smooth surface of the *Journal* paper in order to avoid the bad effects of transparency on the one hand and of "wire mark" or set-off on the other. There has, during the year, been an absence of complaints from advertisers as to poor appearance of blocks and display advertisements.

Postages.—The increase of £346 2s. 7d. in the postage bill is naturally accounted for by the heavier journals and the additional numbers posted.

Special Reports.—The larger figure under this heading represents the cost of producing and printing "Family Meals and Catering," the revenue from which appears as a contra under "Sundry Sales."

Despite the larger membership, the balance required from Subscription Account has been reduced.

ABSTRACT B

22. Although the activities of committees of the Association were intensified, the actual cost of Committee work was somewhat less in 1935 than during the previous year.

The holding of the Annual Representative Meeting in London, followed by the Annual Meeting in Melbourne, to which an official contingent was sent by the Association, resulted in an increased expenditure to the total of £921 2s. 5d. Certain allowances were obtained from rail and steamship companies, which reduced the cost of travel of the individual members of the party, and also reduced very considerably the fares of the official delegation.

Reductions will be especially noticed in the expenditure of some Standing Committees. The Consultants List was not issued during 1935, but on the other hand the *Medical Practitioners' Handbook* in its new form involved a payment of £496 6s.

The figures shown in connexion with the Insurance Acts Committee are as usual net; allowances having been made for reimbursement by the National Insurance Defence Trust of the following items:

	£	s.	d.
Railway fares, 1935	209	17	9
Printings	78	4	10
Clerical assistance	252	10	0
Postage and sundries	63	1	7
	£603	14	2

Representative Meeting.—The attendances for which railway fares have been paid during the past three years are as follows:

1933, Dublin	228
1934, Bournemouth	238
1935, London	180

Council.—The attendance at Council Meetings:

In 1933 incurred 186 fares
In 1934 incurred 206 fares
In 1935 incurred 185 fares

Abstract D

23. *Charges on Loan.*—The repayment of the Bank Loan and the financing of payments during the year saved the charge, which had amounted to £539 19s. 3d. during 1934.

Legal Charges.—Heavy expenditure, which had, however, been foreseen, fell upon the Association in connexion with the successful opposition put up against the Osteopaths Bill; and certain costs were incurred in the establishment of the new Irish Free State Medical Union by the fusion of the Branches of the B.M.A. in the Free State with the Irish Medical Association which was dissolved.

Abstract E

24. The Government Import Duty upon heavy fuel oil continues, and inquiries have been and are being pursued as to the possibility of reverting or converting to some other heating agent. There are, however, structural difficulties about the use of coal or coke.

The amount expended upon repairs and upkeep was considerably reduced during 1935, although certain capital expenditure was incurred through the construction of the offices upon lease in the first floor of Tavistock House North.

An increase under the heading of rates appears to be certain.

Abstract F

25. The reduction under travelling expenses of officials and staff at the Annual Meeting partly sets off the increase recorded in Abstract B.

Certain increases have been paid under the approved scale of salaries: there has been a temporary diminution in the amount of premiums for Deferred Annuities for Officials owing to alterations in the Medical Secretariat.

Abstract H and I

26. *Archives of Disease in Childhood.*—The Income and Expenditure Account shows a substantial increase in the cost of production of the *Archives* resulting in a deficit on the year's working of £341 16s. This additional cost, however, had been anticipated, as the Council had authorized the publication of a special "Sir Thomas Barlow" issue in August, 1935, to commemorate Sir Thomas's ninetieth birthday. The Council is gratified by the excellent reception of, and appreciation expressed for, this special number from all parts of the world.

Including this special issue, the total number of pages published in 1935 was 505, as compared with 378 in 1934, while the number and size of half-tone blocks used to illustrate the *Archives* was also increased.

The *Journal of Neurology and Psychopathology* shows a satisfactory financial result, and the scientific interest and authority of this specialized journal have been maintained.

Trust Funds

27. *Office Staff Superannuation Fund.*—In the past Annual Report of Council attention was drawn to the effects of the alteration in financial values upon such a fund as this. There is still an apparent surplus in the market values of the investments, and an estimate of the future assets and liabilities of the fund would appear to reveal a small margin or surplus.

But when carrying out his quinquennial valuation, the Actuary observed that it would be essential to alter in an upward direction the contributions both of the Association and of the Staff if the Fund is to be found solvent in future years. This warning has been repeated, and the Actuary has been instructed to advise fully on the position of the Fund and any increase in contributions which may be necessary in time for a further report to be made in the Supplementary Report of Council.

Sir Charles Hastings Fund.—Some of the original investments of this Fund, which had for a time only a nominal value, are now appreciating in value.

Central Emergency Fund.—The Trustees realized the 5 per cent. Conversion Loan at a profit in order to meet partially the first payments to be made in connexion with the settlement of an industrial dispute which may have far-reaching consequences, and which will doubtless be reported at length by other Committees.

Estimates of Receipts and Expenditure for the Year 1936

28. The Association has very largely recovered from the difficult financial period which has been recently experienced, and it is a ground for satisfaction that the hopes expressed a year ago, that abnormal expenditure forced upon the B.M.A for legal and political purposes could be met from current revenue, has been realized.

Receipts

	1935 Actual £	£		*1936* Estimated £
Subscriptions	90,112	1,112	Decrease ...	89,000
Advertisements	53,872	2,128	Increase ...	56,000
Sale of *Journals*, etc. ...	8,447	1,047	Decrease ...	7,400
Investments and Rents ...	7,659	1,041	Increase ...	8,700
	£160,090			£161,100

Expenditure

	1935 Actual £	£		*1936* Estimated £
Journal Account Expenses	71,715	1,285	Increase ...	73,000
Central Meeting Expenses	7,479	479	Decrease ...	7,000
Library Account	1,574	106	Increase ...	1,680
General Association Expenses	9,173	*2,623	Decrease ...	6,550
Central Premises Expenses	11,143	1,857	Increase ...	13,000
Central Staff Expenses ...	18,893	1,057	Increase ...	19,950
Central Printing, Stationery and Postage Expenses...	2,980	20	Increase ...	3,000
Scottish Committee ...	2,078	122	Increase ...	2,200
Irish Committee	1,084	1,084	Decrease ...	—
Capitation Grants to Branches	6,915	585	Increase ...	7,500
Subscriptions, etc., written off	4,183	317	Increase ...	4,500
Depreciation, etc. ...	5,598	198	Decrease ...	5,400
Sundry Publications ...	360	160	Decrease ...	200
Sinking Fund	2,433	—	...	2,433
Dominion Currency Reserve	1,000	1,000	Decrease ...	—
Dilapidations Reserve ...	1,500	—	...	1,500
Provision against Commitments for Extension ...	6,000	—	...	6,000
Replacement of Printing Plant Reserve	4,000	4,000	Decrease ...	—
Provision *re* Industrial Dispute	—	*3,500	Increase ...	3,500
Brokerage	14	7	Decrease ...	7
	£158,122			£157,420
Estimated surplus 1936			...	3,680
				£161,100

ORGANIZATION

Membership

29. The following is a summary of the changes in the membership during 1935, the figures for 1934 being shown for comparison.

	1934		1935	
New Members	1,586		1,856	
Paid arrears	1,432		1,280	
Resignations withdrawn ...	36		50	
		3,054		3,186
Resignations	791		767	
Deaths	374		389	
Arrears	1,933		1,675	
Expelled	—		1	
Erased under Art. 9 (*c*) (ii) ...	2		—	
Erased under Art. 9 (*c*) (iii) ...	1		—	
		3,101		2,832

Membership, December 31st, 1934 ... 35,029
Membership, December 31st, 1935 ... 35,383

Work of the Divisions, Branches, and Federal Councils

30. Annual Reports for 1935 have been received from the majority of the Divisions and Branches of the Association, and show gratifying activity. The continued increase in the clinical and scientific activities of the local bodies is noted with particular pleasure.

The number of inactive or unorganized Branches and Divisions compares very favourably with previous years, and efforts are being made to organize those areas which are not working satisfactorily. In this connexion the Council reminds members that for their own sakes, if for nothing else, it is incumbent upon them to see that their Division and Branch are efficient.

On behalf of the Association, the Council wishes to thank the chairmen, presidents, secretaries, treasurers, and executives of the Divisions, Branches, and Federal Councils for their unselfish and unstinted work on behalf of the profession and of the Association.

New Divisions and Branches

31. Since the A.R.M., 1935, the Council has formed a Cyprus Branch, and readjustments have been made in the areas of certain Divisions and Branches, with a view to increasing their effectiveness ; other such readjustments are under consideration.

Division and Branch Rules of Organization

32. A new edition of the Model Rules of Organization has been prepared consequent upon changes in the By-laws made by the A.R.M., 1935.

With the exception of the following, all the Branches and Divisions of the Association in Great Britain and Northern Ireland are in possession of Rules of Organization :

Divisions: Birkenhead ; Derry ; Folkestone and Dover ; Grimsby ; North-East Ulster ; Orkney ; Shetland.

Financing of Branches and Divisions not in Great Britain or Northern Ireland

33. These bodies occupy a specially favoured position, enjoying, in view of their special circumstances, an autonomy far in excess of that of the Divisions and Branches in Great Britain and Northern Ireland. As from 1935, the Council has applied to these Branches the system of variable capitation grants (the system which has been applied for many years to other Branches), according to needs as shown by Annual Reports received. Three Oversea Branches agreed to forego capitation grants in respect of 1935, and one such Branch returned to the Association a sum of money equivalent to more than two years capitation grant.

The Association's Annual Handbook, 1935–6

34. In accordance with the usual procedure the *Annual Handbook* has been issued gratis to members applying for it, as well as to presidents, chairmen, and honorary secretaries of Branches and Divisions and other persons and bodies closely associated with the work of the Association. This edition has been exhausted.

Medical Practitioners' Handbook

35. The first edition of this *Handbook* (superseding the *Handbook for Recently Qualified Medical Practitioners*) was published in October, 1935, and copies were issued to officers of the Association and other persons and bodies closely associated with the work of the Association. Copies of this *Handbook* can be obtained (3s. 6d., or post free 3s. 10d.) from the Financial Secretary and Business Manager or from any bookseller.

The *Handbook* contains Sections as follows: Registration —privileges of medical practitioners ; British Medical Association ; individual medical defence ; main careers open to members of the medical profession ; some practical aspects of medical work ; National Health Insurance ; specialization ; some special degrees and diplomas ; some fellowships, scholarships, studentships, prizes, and research grants open to qualified medical practitioners ; Medical Insurance Agency ; warnings issued by General Medical Council; medical benevolence; rules as to ethics of medical consultation ; memorandum as to the Dangerous Drugs Acts as affecting medical practitioners ; useful addresses.

Medical Students and Newly Qualified Practitioners

36. All the Branches and Divisions in the British Isles in whose areas medical schools exist take steps to promote interest in the work of the Association among the medical students and newly qualified practitioners in their areas.

Of the practitioners qualifying in Great Britain and Ireland in the year October, 1933, to September, 1934, 41 per cent. joined the Association within one year of registration.

Irish Free State Medical Union (Irish Medical Association and British Medical Association)

37. The Council is pleased to report, in continuation of para. 153 of its Supplementary Annual Report for 1934–5, that the constitution of the Irish Free State Medical Union (Irish Medical Association and British Medical Association) became operative as from February 20th, 1936. This Union combines the Irish Medical Association and British Medical Association in the Irish Free State and is, in fact, a corporate group of the Branches of the Association in the Irish Free State, which are entitled to elect three representatives in the Representative Body and one member on the Central Council.

Election of Representatives, 1936–7

38. Subject to adjustments consequential upon changes of Branch and Divisional organization and membership, the Council has repeated the 1935–6 grouping of the Divisions in Great Britain and Northern Ireland for election of Representatives, 1936–7. The Branches in the Irish Free State have three Representatives in the Representative Body. Each Division and Division-Branch outside Great Britain and Northern Ireland has, as in previous years, been made an independent constituency. The complete list of constituencies appeared in the *British Medical Journal Supplement* of April 18th, 1936.

Grouping of Oversea Branches for Election of Nine Members of Council.

39. Pursuant to By-law 57 (*b*) nine members of Council are elected by the Branches of the Association not in Great Britain or Northern Ireland, and pursuant to By-law 60 (2) these elections, save for the filling of casual vacancies, occur every third year, commencing with the year 1935. On February 29th, 1936, a new Cyprus Branch was formed

and the Council has decided that that Branch be grouped with the following Branches in respect of the next election of a member of Council by the Group: Egyptian, Gibraltar, Kenya, Malta, Mashonaland, Matabeleland, Northern Rhodesia, Nyasaland, Palestine, Sierra Leone, Sudan, Tanganyika, Uganda, Zanzibar.

Conference of Honorary Secretaries, 1936

40. The conference of Honorary Secretaries of Divisions and Branches in Great Britain and Northern Ireland will be held at Oxford, in the afternoon of Wednesday, July 22nd, 1936. The Secretaries' Dinner will be held the same evening.

Formation of Special Sections within the Federal Council of the B.M.A. in Australia

41. Arising out of the formation of a number of special associations within the profession in Australia and of proposals to form other such associations, the Federal Council has considered the need for such associations and their influence on the present unity of the medical profession in Australia. Membership of Australian Branches comprises over 90 per cent. of medical practitioners, and many of the Branches in Australia have sections covering most of the specialties. The difficulties which the Federal Council foresaw might arise if further associations were formed, were:

(i) Financial—by the multiplication of calls for annual subscriptions;

(ii) The clashing of independent meetings affecting the attendance at important gatherings;

(iii) Independent action and difference in policy;

(iv) the weakening of the influence of the profession.

The main difficulty experienced by the Federal Council in this respect is that, under its existing constitution, it has always been maintained that a member was entitled to become a member of any section formed by the Association in Australia. The Federal Council therefore asked whether it was possible under its existing constitution to limit the membership of sections and, if not, whether approval could be given to the amendment of the constitution so as to render this possible. The sections would be for purely scientific purposes and would have no medico-political or other activities.

The matter was discussed also between the officials of the Association and the Federal Council at Melbourne on September 10th, 1935.

Counsel's opinion has been obtained, and is to the effect that the formation of special groups of members for the purpose of the exchange of scientific knowledge falls within the objects of the Federal Council, but that it would be advisable, having regard to the constitution of the Federal Council and to its relationship with the British Medical Association, to confer an express power on the Federal Council to form special groups on the lines desired, and that the Articles of Association of the Federal Council should accordingly be altered by inserting a new Article containing express provision to this effect.

The Council agrees that the Federal Council of the British Medical Association in Australia should have power to form under its own aegis scientific sections composed of members of the Association in Australia, and with limited membership, and has advised the Federal Council in accordance with the opinion of counsel referred to above.

Annual Grant to Federal Council of the Association in Australia

42. In 1932 two conferences were held at B.M.A. House between representatives of the Australian Branches who were in this country in connexion with the Centenary Meeting of the Association and Officers of the Association, to consider a request on behalf of the Australian Branches that the annual subscription payable by members of the Association in Australia should be reduced. Eventually it was decided to defer the matter until the Association held its Annual Meeting in Australia in 1935.

The finances of the Federal Council are obtained through capitation payments by the Branches in Australia (membership approximately 4,000), and these Branches cannot afford to pay more than they at present do for this purpose—namely, 2s. per head of their membership. The Federal Council cannot conduct its work effectively and build up a permanent secretariat on its present income.

This matter was discussed in Melbourne on September 10th, 1935, at a conference between the officers and officials of the Association and members of the Federal Council. It was stated on behalf of the Central Council that the need for a secretariat for the Federal Council was realized and that a good case had been made for a grant from central funds.

Subsequently the Council considered an application from the Federal Council for a grant of £1,000 per annum in Australian currency towards the cost of maintaining a secretariat, and the Council agreed to make an annual grant of £1,000 (in Australian currency) to the Federal Council for a period of three years, as a grant towards the expenses of the Federal Council and its secretariat.

Membership List: Election of Representatives; Election of Council

43. Existing By-law 13 (quoted below) is confusing, in that it refers to "a List of Members," "an 'Annual List,'" and "a Register of Members." Strict adherence to its terms creates difficulty as regards voting for members of Council, election of Representatives, and in the conduct of ethical cases. Its wording is not in conformity with that of Art. 17.

Annual List of Members

13. (1) In the month of May in each year a List of Members of the Association (hereinafter referred to as the "Annual List") shall be prepared and published, stating the names and addresses of the Ordinary Members of each Division and Branch as shown by the Register (to be kept by the Association at the Head Office) of Members of the Association on April 30th of that year, and distinguishing the names of such of the Members as are Public Health Service Members.

(2) For all the purposes of the Regulations and the By-laws the persons named in the said List as Members of any Division or Branch and no others shall be deemed to be the Ordinary Members of such Division and Branch, and the persons whose names are so distinguished in the said list and no others shall be deemed to be the Public Health Service Members at the date of the publication of such list.

The Council recommends:

Recommendation: That the amendments to Article 17, and to By-laws 13 (2), 31 (1), 44 (2), and 53 (3), in connexion with the membership list, election of Representatives, and election of Council, as set out in Appendix III, be adopted, and that the Council be instructed to submit the alteration of Article 17 to the necessary General Meeting of the Association.

Election of Members of Council by Groups not in Great Britain or Northern Ireland

44. Existing By-law 60 (4) reads as follows:

> 60 (4).—The said notice (that is, the notice required to be published in the *B.M.J.* regarding the election of members of Council by Groups not in Great Britain or Northern Ireland) shall prescribe a form in which the nominations are to be made, and the nominations shall be made in the form so prescribed, or in a form to the like effect. Nomination papers *may* be signed by not less than three members of any Branch comprised in the Group.

and as it seems obvious that the intention of the second sentence is that "nomination papers *shall* be signed, etc.," the Council recommends:

Recommendation: That the amendment to By-law 60 (4), in connexion with the election of members of Council by Groups not in Great Britain or Northern Ireland, as set out in Appendix III, be adopted.

AMENDMENT OF ARTICLES AND BY-LAWS TO MEET REQUIREMENTS OF BOARD OF TRADE

45. The Board of Trade in intimating to the Association's solicitors that it took no exception to the amendments to the Association's Articles as approved by the A.R.M., 1935, indicated that it would be desirable to transfer from the By-laws to the Articles certain provisions referred to below, so as to bring the Articles more into conformity with the Companies Act, 1929, and modern practice. The solicitors reported that the Companies Act, 1929, stipulated that in the case of a company such as the Association the Articles should include provisions regarding General Meetings, Seal, Notices, etc., and that the Board of Trade looked to the Association to transfer these matters to the Articles.

Recommendation : That the amendments to Articles 10 (*a*), 26, 27, 31, and the new Articles 31, 32, 33, 34, 35, 42, 52, 53, and 54 (including transference from the By-laws to the Articles of By-laws 37–41 and 90–93) to meet the requirements of the Board of Trade, as set out in Appendix III, be adopted, and that the Council be instructed to submit the alteration of Articles 10 (*a*), 26, 27, 31, and the new Articles 31, 32, 33, 34, 35, 42, 52, 53, and 54 to the necessary General Meeting of the Association.

PUBLIC HEALTH SERVICE REPRESENTATIVES ON REPRESENTATIVE BODY AND COUNCIL

46. The Council of the Society of Medical Officers of Health has suggested that the Association should consider amending its constitution so as to allow of the election as " Public Health Service Members " of the Representative Body and Council, medical practitioners the whole of whose time is spent as teachers of public health but who have had long experience as medical officers in the service of local authorities.

The Council is in sympathy with this suggestion, and recommends:

Recommendation: That the amendment to By-law 1 (3), in connexion with the Public Health Service representatives on Council and Representative Body, as set out in Appendix III, be adopted.

CONSTITUTION OF HOSPITALS COMMITTEE

Recommendation: That the amendment to the Schedule to the By-laws relating to the Hospitals Committee, as set out in Appendix III, be adopted.

CONSTITUTION OF PUBLIC HEALTH COMMITTEE

Recommendation : That the amendment to the Schedule to the By-laws relating to the Public Health Committee, as set out in Appendix III, be adopted.

INSURANCE ACTS COMMITTEE: CHAIRMAN AND DEPUTY CHAIRMAN OF

Recommendation : That the amendment to By-law 82 and the Schedule to the By-laws relating to the Insurance Acts Committee, as set out in Appendix III, be adopted.

OTHER ALTERATIONS OF ARTICLES AND BY-LAWS

47. Arising out of the perusal of the Articles and By-laws referred to in the foregoing Recommendations, certain other amendments are suggested in the following Recommendation:

Recommendation : That the amendments to Articles 30 and 38, and By-laws 5 (3), 12, 36 (2), 47 (2), 47 (4), 48 (3), 62, 73, and 89, and the renumbering of Articles 32–37 and 38–46 and of By-laws 42–89, as set out in Appendix III, be adopted, and that the Council be instructed to submit the alteration of Articles 30 and 38 to the necessary General Meeting of the Association.

SUBSCRIPTION OF RETIRED PRACTITIONERS

48. The Council has considered the following resolution of the A.R.M., 1935:

Minute 30.—Resolved: That (with reference to paras. 22, etc., of the Annual Report of Council relating to the Balance Sheet) the Council be instructed to explore the possibility of permitting medical practitioners retired from practice to remain members of the Association at a subscription lower than the £2 2s. now obtaining.

As from January 1st, 1921, the ordinary subscription for United Kingdom members was raised from £2 2s. to £3 3s., and as from January 1st, 1922, the subscription of " retired members " was adopted, as follows:

> Any member of not less than ten years' standing as such who has definitely and permanently retired from the active practice of the medical profession and has signed and transmitted to the Treasurer a declaration to that effect ... ... Two guineas.

At present there are approximately 600 retired members who are paying the reduced subscription of £2 2s. under this provision.

In view of the fact that the " retired members " already pay a considerably reduced subscription rate, and that any concession to such members would almost certainly be followed by applications for reduced subscription in respect of other sections of members, and that such applications, based on any reduction in the subscription rate of " retired members," would be very hard to resist, the Council cannot see its way to suggest a reduced subscription for " retired members," and therefore recommends:

Recommendation: That no further reduction be made in the rate of subscription for " retired members."

SOCIAL ACTIVITIES BY DIVISIONS AND BRANCHES

49. From time to time the Council is asked whether Divisions and Branches may pay, out of the Association money in their hands, for the entertainment of members in connexion with annual meetings of Divisions and Branches and for other social purposes.

The Council has always replied to such inquiries that it is contrary to the practice of the Association that such expenditure should be met out of Association funds in the hands of Divisions and Branches, and that if a number of Divisions and Branches embarked on such expenditure the income of the Association would not be sufficient to meet the demands made upon it in connexion with all its various activities. Further, that such expenditure should be met out of money raised voluntarily by the Divisions and Branches. Quite a large number of the local units of the Association have raised funds for this purpose.

"BRITISH MEDICAL JOURNAL"

50. The Council believes that the *British Medical Journal* during 1935 has kept its high position among the professional and scientific periodicals of the world, and that its value to the general practitioner is increasingly recognized at home and abroad. Evidence of the close attention paid to its contents by members in all branches of practice, and not least by general practitioners, is provided by the very large number of letters for publication that reach the Editor week by week. The heavy claims on the correspondence columns, and indeed on every section of the paper, were responsible for a further increase in the total number of pages of letterpress. In the choice and presentation of material published in the *Journal* and *Epitome* the aim has always been to supply members with a weekly periodical giving them a comprehensive review of progress in the science and practice of medicine. The main function of the *Supplement* is to keep members informed of the course of the business of the Association and of the numerous directions in which it acts as the medico-political organization of the profession. Much of this matter is of a kind that would not be published so fully in a journal conducted as a com-

mercial undertaking, but efforts have been made during the past three years, by co-operation between the Editorial and the Medical Departments, to present such information in a more attractive form. The Council believes that this policy is approved by members, and that those engaged in medical work under the Insurance Acts value the prominence given in the *Supplement* to their interests and problems. In most other periodicals a Supplement, in addition to providing special news for its readers, is also used as a source of increased revenue from advertisements ; but this practice has not hitherto been applied to the weekly *Supplement* of the *British Medical Journal*.

Typography of Journal

51. Brief references have appeared in this section of the Annual Report of Council during recent years to various improvements which have been effected in the printing and "lay-out" of the *British Medical Journal*, beginning with the introduction of special photogravure plates in November, 1930. It became increasingly evident, however, that while improvement had been achieved in a number of directions and that many criticisms had been met, much yet remained to be done. The possibility of technical improvements on a larger scale has been under continuous investigation during 1935 by special sub-committees of the Journal Committee. The Journal Committee has reported fully to the Council at its April meeting, and further reference to the matter will be made in the Supplementary Report of Council.

Special Series

52. So far as the literary contents of the *Journal* are concerned, mention must again be made of the new feature introduced on December 8th, 1934, when there appeared the first of a weekly series of signed articles, contributed by invitation, on the "Management of Major Medical Disorders met with in General Practice." The aim of this, and of later articles for the general practitioner, is to present readers with concise yet detailed information on current therapeutics by recognized teachers of clinical medicine and surgery. The series has been continued week by week, except in the month of August, and in response to requests from many members the Council authorized the republication of the first three groups of articles in book form. These articles were devoted to (*a*) diseases of the respiratory system ; (*b*) acute infectious fevers ; (*c*) cardiovascular affections. They have now been issued in a handy volume of 260 pages by Messrs. H. K. Lewis & Co. Ltd., at the price of 8s. 6d., under the title *Treatment in General Practice*. The series of occasional medico-legal articles which proved very popular in 1933 and 1934 is likewise being republished in book form, under the name of their author, Mr. D. Harcourt Kitchin, barrister-at-law, by Messrs. Edward Arnold and Co.

Some Figures—and a Request

53. The average weekly number of pages in the *British Medical Journal* in 1935 was 129.84 distributed as follows:

Journal and *Epitome*	54.769
Supplement	11.923
Advertisements	63.153

The total number of pages of text and advertisements was 6,752, as compared with 6,396 in 1934, 6,338 in 1933, and 6,572 in 1932. These figures do not include the half-yearly indexes or special plates on art paper.

The Council appeals once again to members when sending communications to the Editor for publication to bear in mind the great variety of scientific and professional interests which rightly look to find representation in the pages of the *Journal*. In 1935 no fewer than 1,008 addresses, papers, and clinical memoranda were submitted, and of these it was possible to publish 544. While the Editor takes pains to choose articles which are likely to prove most acceptable to the majority of members, an endeavour is made throughout the year to provide material of interest to all sections, even those not largely represented in the general membership. An appeal has been made to contributors to summarize their articles and set out their conclusions in a terminal paragraph ; while cross-headings are now inserted more freely in order that the reader, who cannot be expected to peruse the whole *Journal*, may grasp the gist of the principal contents. If further improvements in appearance and lay-out are to be achieved a greater conciseness may be necessary, especially in correspondence. While it is desirable to encourage this section of the *Journal*, members would assist greatly by confining their remarks within the briefest compass.

Proceedings at the Melbourne Meeting

54. The Annual Meeting was held in Melbourne six weeks later than the usual date, and publication of the Presidential Address and opening papers in the various discussions did not therefore begin until September 14th. For this reason it was impossible to dispose of the material from the Sections by the end of the year, and in fact the last of the Melbourne opening papers did not appear until March 7th, 1936. By arrangement with the Board of the *Medical Journal of Australia*, the Editor of that journal, Dr. Mervyn Archdall, undertook responsibility for the Sectional reports on behalf of the *British Medical Journal*. These summary reports of proceedings were dispatched by Dr. Archdall by air mail, and reached London safely, thus permitting their publication in four consecutive issues (October 12th, 19th, and 26th, and November 2nd, 1935). The total number of pages of the *British Medical Journal* devoted to scientific and clinical proceedings at the Melbourne meeting—including the three opening papers published together on February 1st, 1936, as a special Supplement, entitled "Some Medical Problems of Australia," and the reports of the fourteen Sections and the Presidential Address—was 244. The full reports of the Annual Representative Meeting, and the statutory Annual General Meeting, etc., held in London at the end of July occupied fifty pages. Miscellaneous reports, announcements, etc., relating to the Melbourne meeting occupied twenty-three pages of the *Journal* and *Supplement*.

Cost of Production and Distribution

55. The *Journal* account, published in Abstract A of the Annual Financial Statement, shows the gross cost of the production and distribution of the *British Medical Journal*, including all editorial and a portion of the managerial expenses. The figure was £71,715 3s. 5d. in 1935, compared with £67,643 3s. 2d. in 1934. It must not be forgotten, however, that the *Journal* account as set forth in the Financial Statement does not bear any proportion of the cost of construction or maintenance of the premises in which the *Journal* is produced, nor does it allow for depreciation of the plant and type. The revenue from advertisements amounted to £53,871 15s. 10d. in 1935, compared with £50,672 9s. 5d. in 1934.

Censorship of Advertisements

56. While the acceptance of advertisements is not to be understood to imply a recommendation or guarantee, and while no responsibility can be accepted with regard to the accuracy of the statements contained in advertisements, a very strict censorship is maintained by the Journal Committee. The cash value of advertisements which, in pursuance of the Association's policy, have been declined or discontinued represents a large sum, but the policy of excluding undesirable advertisements from the official organ of the Association is a duty which the Council feels it owes to the members of the medical profession. All new advertisements submitted for publication are scrutinized in the Finance or Medical Departments. Details of advertisements suspended or refused and of the grounds for the action taken are periodically reviewed by the Journal Committee.

"Archives of Disease in Childhood"

57. Early in 1926 the Council of the Association decided, in response to the wishes of many members interested in paediatrics, to issue a periodical which would worthily represent the British school by recording the

investigations and conclusions, clinical and pathological, of all its workers. The first number of the *Archives of Disease in Childhood* appeared in February, 1926, and the tenth volume was completed with the number dated December, 1935. The joint Editors are Dr. Charles Harris and Dr. Alan Moncrieff, and an Editorial Committee meets periodically, under the chairmanship of Dr. G. F. Still. The issue dated August, 1935, was a special commemorative number in honour of Sir Thomas Barlow's ninetieth birthday on September 4th. It comprised a series of essays, written for the occasion by Dr. Still and others, with an introduction by Lord Horder. The *Archives* is issued six times a year, and the subscription (post free) is 25s., payable to the Financial Secretary, British Medical Association, Tavistock Square, W.C.1, subscription for Canada and the United States, 6 dollars (post free) ; price of single numbers, 4s. 6d.

"Journal of Neurology and Psychopathology"

58. Since midsummer, 1926, the *Journal of Neurology and Psychopathology* has been issued by the British Medical Association, and the sixty-second number appeared in October, 1935. Its contents include original communications and editorial articles, together with abstracts of current neuro-psychiatric literature, and critical reviews ; and the scope and arrangement of this journal are such that it fills a place which no other published in English exactly occupies. The *Journal of Neurology and Psychopathology* is edited by Dr. S. A. Kinnier Wilson, with the assistance of an Editorial Committee, and under his guidance it has established itself as one of the foremost periodicals for the record of progress in the branches of medicine with which it deals. It is published quarterly, and the subscription of 30s. a year is payable to the Financial Secretary, British Medical Association, Tavistock Square, W.C.1. The price of a single number is 8s. 6d. (post free).

SCIENCE COMMITTEE

Remuneration of Medical Non-Professorial Teachers and Research Workers

59. The policy of the Association regarding the remuneration of medical non-professorial teachers and research workers is as follows:

(a) Whole-time

Whole-time (1) non-professorial medical teachers, and (2) medically qualified laboratory or research workers, should be grouped into three grades as defined below, and with the salaries as stated:

Grade III. Comprising those who are junior workers temporarily employed on probation ; no person should remain in Grade III for more than three years.

The minimum salaries for Grade III should be as follows:

1st year	£300
2nd year	£350
3rd year	£500

Grade II. Comprising laboratory or research workers or teachers who have had three years' experience in Grade III, or in work of a similar character, and who are permanently and exclusively employed as such.

The minimum commencing salary for Grade II should be £600 per annum.

Grade I. Comprising those of Grade II whose qualifications or duties justify a position of seniority in status and a higher remuneration.

The minimum salary for Grade I should be £750 per annum.

After the probationary period (that is, Grade III) has been completed, the tenure of any appointment should not be terminated without reasonable notice on either side, and dismissal should not be possible except in the case of neglect of duty or improper conduct. (A.R.M., 1926, Min. 33 ; A.R.M., 1929, Min. 162.)

The above scale of salaries relative to non-professorial medical teachers, laboratory, and research workers, should not apply to those academic appointments in universities and medical schools which are of a temporary character and where the duties attached to the posts are in direct connexion with the advancement of the practitioner's knowledge and experience in the particular branch of work which he proposes to cultivate. (A.R.M., 1928, Min. 52.)

(b) Part-time

Non-professorial medical teachers and medically qualified laboratory or research workers, holding part-time appointments, should receive remuneration for the time engaged, at the rate of not less than £600 per annum. (A.R.M., 1926, Min. 33.)

Considerable difficulty having been experienced by the Medical Secretariat in carrying out this policy owing to the operation of the exemption clause contained in Minute 52 of the A.R.M., 1928, with a view to obviating this difficulty the A.R.M., 1935, passed the following resolution:

> *Minute 196.*—Resolved: That, pending consideration by the A.R.M., 1936, of a definite recommendation to rescind Minute 52 of the A.R.M., 1928 (which permits exemption from the scale of salaries laid down for non-professorial medical teachers and laboratory and research workers, of those academic appointments in universities and medical schools which are of a temporary character and calculated to advance the practitioner's knowledge and experience) of which the requisite two months' notice will be given, the Secretariat be authorized in dealing with advertisements to interpret the policy of the Association in regard to non-professorial teachers and laboratory and research workers as if Minute 52 of the A.R.M., 1928, had been rescinded.

Two months' notice is necessary for the rescission of Minute 52 of the A.R.M., 1928, and the Council therefore recommends:

Recommendation : That the following Minute 52 of the A.R.M., 1928, be rescinded:

> *Min. 52.*—Resolved: That the scale of salaries relative to non-professorial medical teachers, laboratory and research workers, should not apply to those academic appointments in universities and medical schools which are of a temporary character and where the duties attached to the posts are in direct connexion with the advancement of the practitioner's knowledge and experience in the particular branch of work which he proposes to cultivate.

Scientific Sections at Annual Meeting, 1936

60. The following Sections will meet in connexion with the forthcoming Annual Meeting in Oxford:

Three-day Sections.—Medicine ; Surgery ; Obstetrics and Gynaecology ; Pathology and Bacteriology.

Two-day Sections.—Anatomy ; Diseases of Children ; Neurology and Psychological Medicine ; Ophthalmology ; Orthopaedics ; Oto-Rhino-Laryngology ; Pharmacology and Therapeutics, with Anaesthetics ; Physical Medicine ; Physiology and Biochemistry ; Radiology ; Tuberculosis.

One-day Sections.—Dermatology ; History of Medicine ; Medical Sociology ; Nutrition ; Public Medicine.

The Association's Scholars and Grantees, 1935-6

61. During the year 1935–6 the Council allocated for the direct encouragement of original investigation and research £1,000, from which the following awards were made:

Ernest Hart Memorial Scholarship (£200)

Kerr, A. S. (London), M.B., Ch.B., F.R.C.S.	An investigation into the functions of specific areas of the brain with special reference to the hypothalamus.

Walter Dixon Memorial Scholarship (£200)

Brock, J. F. (London), M.A., B.M., B.Ch., M.R.C.P.	To continue researches into the assimilation of iron by the human organism started during tenure of Leverhulme Research Scholarship: (1) the retention of iron when small doses of soluble ferrous salts are used ; (2) to repeat if possible the recent work of Mather, Kellogg, and Rhinehart (1934) with the addition of an iron balance study to determine whether the greater response is due to a greater assimilation of iron or to other factors, and thus to throw light on the aetiology of idiopathic hypochromic anaemia.

Ordinary Research Scholarships (£150 each)

Anderson, C. S. (Liverpool), M.B., Ch.B.	(1) The histological investigation of cases of carcinoma of the lungs for evidence of associated pneumokoniosis. (2) The investigation of the silica content of normal lungs and carcinomatous lungs with a view to establishing the relationship between silica irritation and malignancy. (3) The injection into mice of silica and allied dusts with a view to establishing silica as a carcinogenic agent.
Evans, M. D. A. (Cardiff), M.D., F.R.C.S.Ed.	(1) To continue a research into the after-effects of the toxaemias of pregnancy and how to avoid them. (2) To investigate the recently discussed problem of the increase of weight in the pregnant woman as an early sign of toxaemia.
Muir, E. G. (London), F.R.C.S., M.S.	Experimental intestinal obstruction, with particular reference to gastric secretion and the associated blood changes in this condition.

Research Grants

Elizabeth H. Lepper (London), £30 ; Jocelyn A. M. Moore (London), £15 ; C. G. Paine (Sheffield), £30 ; J. H. Saint (Newcastle-on-Tyne), £10 ; Joan Taylor (London), £40 ; C. E. Van Rooyen (Edinburgh), £25.

Work of Scholars and Grantees, 1934–5

62. Satisfactory reports have in all cases been received from the members of the Association who examined the work done by the Scholars and Grantees for 1934-5. Papers have been contributed by Scholars and Grantees to various scientific journals, and a synopsis of the work carried out was published in the *Supplement* to the *British Medical Journal* of September 7th, 1935.

The Library

63. The past year has proved a very active one so far as the Library is concerned, members (particularly those from the Provinces) continuing to take advantage in increasing numbers of the facilities offered. During the past seven years the circulation of books has increased by 150 per cent., and in order that a satisfactory service may be maintained it has been necessary to increase the Annual Library Grant for the purchase and supply of books from £400 to £500. Requests by members for references and literature on specific subjects form an important part of the Library work.

The Council acknowledges receipt during 1935 of 336 presentations of books to the Library, including calendars, reports, and society transactions.

During the year the Library has been redecorated and the lighting system considerably improved.

B.M.A. Lectures

64. The system of B.M.A. Lectures increases in popularity. Under this scheme each Division and Branch in England, Scotland, Wales, and Northern Ireland may have one such lecture during the course of the year, the expense being borne by the central funds of the Association. From April 1st, 1935, to March 31st, 1936, the following have given B.M.A. Lectures, and the Council desires to express its thanks for the services rendered by these lecturers to the profession and to the Association: Dr. D. K. Adams, Dr. E. W. Adams, Dr. H. Tuke Ashby, Dr. H. W. Barber, Dr. William Brown, Mr. Hugh Cairns, Dr. H. C. Cameron, Dr. E. G. B. Calvert, Dr. Godfrey Carter, Dr. H. Crichton-Miller, Sir Stewart Duke-Elder, Mr. R. C. Elmslie (two), Dr. R. Fortescue Fox, Professor John Fraser (two), Dr. R. D. Gillespie, Mr. G. R. Girdlestone, Dr. F. Temple Grey, Mr. W. Sampson Handley, Professor John Hay, Dr. C. M. Hinds Howell, Dr. A. F. Hurst (two), Dr. Robert Hutchison, Mr. Geoffrey Jefferson (two), Captain Jervis, Professor R. W. Johnstone, Mr. Cecil A. Joll, Mr. Norman C. Lake, Mr. C. Lambrinudi, Sir Walter Langdon-Brown, Dr. R. D. Lawrence, Dr. H. MacCormac, Dr. J. B. Mennell (two), Dr. A. Mitchell, Dr. E. P. Poulton, Dr. F. J. Poynton (two), Dr. C. Price-Jones, Dr. J. R. Rees, Dr. J. M. Robson, Professor A. Rendle Short, Professor M. J. Stewart, Dr. Kenneth Tallerman, Dr. F. G. Thomson, Professor W. W. D. Thomson, Dr. H. Letheby Tidy, Mr. C. P. G. Wakeley, Mr. Kenneth Walker, Dr. Leonard Williams, Professor L. J. Witts, Professor W. H. Wynn, Professor James Young.

Sir Charles Hastings Clinical Prize, 1936

65. The Sir Charles Hastings Clinical Prize, consisting of a certificate and cheque for 50 guineas, which was established by the Council in 1924 for the promotion of systematic observation, research, and record in general practice has been awarded for the year 1936 to A. F. Kerr Clarkson, M.B., Ch.B.Ed., of Newcastle-on-Tyne, for his clinical study entitled " 300 Cases of Asthma in General Practice." The essay reviews and analyses 300 cases of asthma seen in general practice over a period of five years, and gives a running comment on the literature. It is of a high order of merit, and shows evidence of careful observation and research.

Special letters of commendation have been sent to the following: Clark Nicholson, M.C., M.D., Moreton-in-Marsh ("An Experiment in Pelvimetry by *X* Rays") and A. Hamilton Harvie, M.B., F.R.C.S.Ed., Jagadhri, Punjab (" Amoebiasis Clinically Observed in its Natural Environment ").

The Council has expressed its cordial thanks to Sir Humphry Rolleston and Professor F. R. Fraser, who examined the ten essays submitted for this prize.

Katherine Bishop Harman Prize, 1936

66. This Prize (consisting of a cheque for £75 and a certificate) is awarded biennially, and has for its purpose the encouragement of study and research directed to the diminution and avoidance of the risks to health and life which are apt to arise in pregnancy and child-bearing. In respect of 1936 it has been awarded jointly to G. A. W. Wickramasuriya, F.R.C.S.Ed., Colombo, for his clinical study entitled " A Close Investigation into the Problems of Malaria and Ankylostomiasis as Factors in Maternal and Foetal Mortality in the Tropics," and to Arthur M. Hill, M.B., of Melbourne, for a clinical study on " Post-abortal and Puerperal Gas Gangrene."

The Council has expressed its cordial thanks to Sir Ewen Maclean and Professor F. J. Browne for their services in examining the twelve essays submitted in competition for the Prize.

Middlemore Prize, 1936

67. This Prize, which consists of a cheque for £50 and a certificate and is given triennially for the best essay or work on any subject which the Council may from time to time select in any department of ophthalmic medicine or surgery, has been awarded in respect of the year 1936 to Arnold Sorsby, M.D., F.R.C.S., of London. The subject chosen for competition was " The Aetiology, Prophylaxis, and Treatment of Myopia, especially in its Higher Degrees." The essay is of a very high standard, contains much original work involving no small amount of clinical research, and shows a sound knowledge of the current literature, which is dealt with in a critical and thoughtful manner.

The Council has expressed its cordial thanks to Sir Stewart Duke-Elder and Mr. A. J. Ballantyne, who examined the four essays submitted for the Prize.

Library of British Post-Graduate Medical School

68. The Council has collected and presented to the library of the British Post-Graduate Medical School a set of the *British Medical Journal* and its predecessor *The Provincial Medical and Surgical Journal,* since its inception. The following acknowledgement has been received from Sir Austen Chamberlain, chairman of the Governing Body of the School:

23rd November, 1935.

Dear Sir,

On behalf of the Governing Body of the British Post-Graduate Medical School I have to acknowledge the receipt of your generous gift of a complete set of the *British Medical Journal* from 1833.

Will you please convey to the President and members of the British Medical Association the appreciation and grateful thanks of the Governing Body for this very rare and valuable gift. It will form one of the treasures of the library now in process of formation.

Yours sincerely,
(signed) AUSTEN CHAMBERLAIN.

The Council expresses its thanks to those members and institutions who have so kindly assisted it in collecting certain missing volumes. One volume still remains to be obtained—namely, 1860.

ANTI-CHEMICAL WARFARE

69. The Council has had before it the following resolution of the A.R.M., 1935:

Min. 170.—Resolved: That in the opinion of the Representative Body instruction in the anti-chemical warfare measures should be given to medical students.

Min. 171.—Resolved: That instruction in the anti-chemical warfare measures should be available for post-graduates.

Min. 172.—Resolved: That in view of necessity for educating the public in measures of protection against chemical warfare, the British Medical Association should ask for the co-operation of its members.

Min. 173.—Resolved: That the following be referred to the Council for consideration:

That we as an Association should concentrate and use our influence on the prevention and total abolition of all chemical warfare.

The question of the protection of the community against the effects of chemical warfare is at the present time under serious consideration by the Air Raid Precautions Department of the Home Office, and before making any definite proposals the Council is exploring the situation with that Department.

PROPRIETARY REMEDIES

70. The Council is continuing its discussions with the Pharmaceutical Society in regard to proprietary remedies offered to the profession and the possibility of collecting and disseminating in some convenient form information concerning the composition and therapeutic activity of these preparations. In the opinion of the Council the position is such as to demand serious consideration, but with the knowledge at present available it is difficult to arrive at any useful conclusion. A trial investigation is therefore being made into certain groups of preparations, with the object of producing information which will allow the Council adequately to review the situation.

NATIONAL REGISTER OF MEDICAL AUXILIARIES

71. The necessary preliminaries connected with the inception of the National Register of Medical Auxiliaries have now been completed. The controlling body of the register—The Board of Registration of Medical Auxiliaries—has been duly incorporated as a company under the Companies Act, and the compilation of the register will be proceeded with forthwith.

MEDICAL ETHICS

"BINDING" RESOLUTIONS OF DIVISIONS ON CERTAIN MATTERS OF ASSOCIATION POLICY

72. The Council has urged the Divisions to adopt "binding" resolutions under their ethical rules in regard to the following subjects of Association policy:

(i) Memorandum of recommendations as to salaries and conditions of service of whole-time public health medical officers;

(ii) Provision of domiciliary attendance by consultants in private practice and not by whole-time medical officers:

(iii) Provision of domiciliary attendance upon public assistance patients by private practitioners and not by whole-time medical officers;

and the Council is glad to report that a considerable number of Divisions have taken the necessary action for the adoption of the appropriate resolutions.

There are, however, many Divisions which have so far taken no action, and the Council again draws the attention of these Divisions to the desirability, in their own interests and those of the profession generally, of adopting "binding resolutions" under their Ethical Rules in relation to the above subjects. On each of these a definite policy relating to salaries and other conditions has been decided by the Representative Body. The co-operation of the Divisions is now invited in the application of these policies. The best way to do this is for each Division to pass for its own area a "binding resolution"—that is, an announcement of the policy of the Association to the members of the Division. The rule being thus plainly stated, no one concerned can plead ignorance of its existence, and provision is made in advance for applying it in any instance in which it may be disregarded. Thus should a local authority within the area of the Division propose to make an appointment on terms opposed to the Association's Rules, the Division is prepared at once to submit representations on the subject. On the other hand, to wait until such an appointment is offered or accepted means that the Division is not ready for the event and can act only at a disadvantage. With the "binding resolution" the Division is ready; without, it will be late or perhaps too late. Again and again a Division desiring to apply one or other of the above policies of the Association has had reason to regret that it has not adopted in advance the corresponding "binding resolution."

If Divisions throughout the country will adopt resolutions upon the subjects referred to them by the Council such action will have a twofold effect—namely, (i) it will act as a powerful deterrent to practitioners from accepting appointments which are contrary to the policy of the Association, and (ii) it will also be a factor of considerable importance with local authorities.

For the reasons set out above, those Divisions which have so far taken no action for the adoption of "binding resolutions" are urged to do so forthwith.

LECTURES OF THE BRITISH EMPIRE CANCER CAMPAIGN

73. The Council has been approached by the British Empire Cancer Campaign in reference to a proposal of that body to institute an educational campaign throughout the country with a view to the education of the public as to the necessity of early diagnosis of malignant disease. It is proposed to form a panel of medical lecturers in the large centres, the local Divisions of the Association being approached for this purpose. The Council has informed the British Empire Cancer Campaign that it sees no objection on principle: (*a*) to the Divisions of the Association being invited to co-operate in the proposed lecture arrangements, nor (*b*) to the announcement of the names of those practitioners who are giving the lectures.

MEDICO-POLITICAL

TREATMENT UPON CONTRACT TERMS OF PERSONS WITH INCOMES ABOVE £250 PER ANNUM

74. The existing policy of the Association upon the above question is stated in the following Minute 109 of the Annual Representative Meeting, 1920:

Min. 109.—Resolved: That the Representative Body adopt the following principles as essential to the formation of any schemes for the provision of medical attendance and treatment of uninsured persons:

1. That, in general, in considering the necessity for obtaining the approval of the Council for schemes for the treatment of uninsured persons upon contract terms, the following principles and conditions must be adhered to:

(*a*) Free choice of doctor by patient and of patient by doctor;

(*b*) Remuneration to be not less than that which is deemed by the Council to be equivalent to that paid in respect of insured persons;

(*c*) Persons with a total income from all sources of £250 per annum or upwards, or the dependants of any such person, not to be treated under contract terms at all.

2. That the Representative Body realizes that the conditions in certain areas will not allow of the above terms being obtained, and that in these circumstances the approval of the Council may be given provisionally to a scheme involving a less payment when the local profession can show that the economic conditions in the area demand it.

3. That one of the conditions necessary for the approval of schemes containing lower rates of payment shall be the inclusion amongst the rules, in a prominent position, of a statement that approval by the Association has been given to the rates only because of special economic conditions,

which the Council was instructed by the A.R.M., 1935 (Minute 88), to amend so as to permit the Council to sanction a higher income limit should the local profession desire it.

It is clear that if persons with incomes above £250 per annum are to be afforded medical attendance under contract arrangements the practitioner should be entitled to a rate of remuneration which is higher than that indicated in Clause 1 (*b*) of the existing policy. Accordingly, any amendment of that policy on the lines laid down in Minute 88 of the A.R.M., 1935, must allow both for revised income limits and for increased standards of remuneration to the practitioner:

The Council recommends:

Recommendation: That Minute 109 of the A.R.M., 1920, be amended (*a*) by the deletion of the words "at all" in subparagraph 1 (*c*), and (*b*) by the substitution of the following for paragraph 2 of that Minute:

2. That the Representative Body realizes that the circumstances of some areas justify a modification of the above conditions, and in such circumstances the approval of the Council may be given provisionally to a scheme involving other payments, or different income limits, when the local profession can show that the circumstances in the area demand it.

The Medical Services in Llanelly and District

75. The Council reported fully to the Divisions and the A.R.M., 1935, upon the dispute which had arisen in Llanelly in connexion with the medical services of that area, and the Council was instructed to continue its efforts to secure a complete and satisfactory settlement of the dispute.

The Council is glad to report that in October, 1935, an agreed settlement was reached, which provided for the establishment, as from January 1st, 1936, of a new medical service for Llanelly and district. In view of the gravity of this dispute, and having regard to possible repercussions on medical services elsewhere, it is appropriate to recall briefly the principles which were involved and the final terms of settlement.

History of the Dispute

For several years prior to the differences which led to the dispute the workmen, both married and single, paid a monthly capitation rate as a provision for general practitioner attendance upon their dependants, supply of ordinary medicines, and specialist ophthalmic and ear, nose, and throat services.

In March, 1934, the Workmen's Medical Committee announced its intention of introducing into the area a whole-time surgical specialist, whose remuneration would be made available by means of a reduction in the amounts paid to the general practitioners. Believing that the rates paid to the general practitioners for medical service to the dependants were fair and reasonable, and although not objecting in principle to the introduction into the area of a surgical specialist, the local profession, with the full support of the Association, strongly opposed the proposed reduction in remuneration. Despite negotiations it was not found possible to reach an agreement with the Workmen's Medical Committee, and the existing arrangements terminated.

The Workmen's Medical Committee subsequently decided to set up under its own auspices and control a new service, including general practitioner, surgical, ophthalmic, and ear, nose, and throat services, the practitioners being employed on a whole-time salaried basis. The doctors in the area continued to give service at the old rates to a majority of the workmen, at the same time establishing a public medical service. Thus there existed in Llanelly two parallel but distinct medical services, one provided by the private practitioners and the other by salaried whole-time practitioners in the employ of the Workmen's Medical Committee.

The agreement reached between the disputing parties provided for the establishment of a new service based on the following principles:

(i) Free choice of doctor and patient.

(ii) Remuneration of general practitioners for general practitioner service at the rate obtaining before the dispute (subject to a deduction for administrative purposes) to be paid into a practitioners' fund.

(iii) No whole-time appointments.

(iv) The service will include a general practitioner service and aim at a complete consultative and specialist service.

(v) The local method of organization to be based on the existence of a Management Committee consisting of representatives of the subscribing workmen (forming a Lay Subcommittee) and an equal number of representatives of the practitioners giving service (forming a Medical Subcommittee), with an agreed independent chairman.

(vi) Every general practitioner practising within the area who is entitled to have his name included in the list of the Insurance Committee under the National Health Insurance Acts to be entitled to participate in the service.

(vii) The terms of service will, as nearly as may be, provide similar rights as to change of patient and termination of doctor's appointment as are provided under the National Health Insurance Acts.

(viii) Payment will be made by the workmen into a consultants' fund, out of which consultants will be remunerated on a sessional basis or on a payment per item of service basis. Only the Management Committee may, however, appoint consultants on a part-time salaried basis which bears some relation to the sessional or item of service basis.

The Workmen's Medical Committee also terminated the appointments of the doctors in its employ on a salaried basis, except the surgeon, who holds an appointment under the new consultants' scheme.

Public Medical Services

76. In accordance with the instructions of the Annual Representative Meeting, 1935, the Council convened a conference of representatives of public medical services. The conference was extremely well attended, practically every public medical service in the country being represented, and it afforded an excellent opportunity for an exchange of views of those practitioners who are interested in this type of contract medical service. A further such conference will be held in the autumn of this year.

National Deposit Friendly Society

77. In January, 1935, the National Deposit Friendly Society made a reduction in its scale of medical fees by substituting an item "fee of 2s. for a fresh supply of medicine for four days" for the item "supply of medicine for two days—fee 1s. 6d." This change in the scale was discussed between representatives of the society and the Association, but although the society's representatives agreed to bring before its annual general meeting a recommendation for the revision of the scale, that body decided to adhere to its decision. As a result, the Representative Body (Minute 189) expressed its disapproval of the action of the society in altering a negotiated scheme without previous consultation, and instructed the Council to consider the question of withdrawing its approval of the whole scale.

The Council has issued a circular letter to the Divisions drawing attention to the facts (1) that when the scale of

fees of this society was dealt with by the Association in 1920 it was indicated in the Annual Report of the Council that a practitioner was under no obligation to attend members of the society at the rates paid by the society, but could treat them as private patients, accepting the National Deposit Friendly Society fees as part payment; and (ii) that this position is clearly understood by the society, and is acted upon in many parts of the country.

The Council has reminded Divisions that practitioners can properly regard the fees paid by the National Deposit Friendly Society for medical attendance upon its members as a "grant-in-aid" towards the cost of the practitioner's charges. Where the amount paid by the society does not cover the practitioner's ordinary charges he is entitled to charge the patient with the difference between his fees and the amount received from the society.

A deputation from the Association again met the society's representatives and requested that a statement indicating that the scale must be regarded by its members as a "grant-in-aid" should be made on the society's forms, or alternatively that the Association would feel justified in issuing leaflets which practitioners might hand to their patients making it clear that the Association did not approve of the present scale.

The society's representatives undertook to press on their annual general meeting the desirability of revising the scale to conform to the Association's suggestions, and requested that the Association should defer further action pending the society's decision. This the Council has agreed to do.

Non-Nationals and the "Medical Register"

78. The Council has made representations to the Combined Scottish Colleges in reference to the question raised in the following Minute 179 of the A.R.M., 1935:

> *Min. 179.*—Resolved: That in view of the fact that certain non-nationals are being admitted to the *Medical Register* after only an abbreviated course of study in the British Isles, and are coming into competition with our own practitioners, the Representative Body instructs the Council to continue to press for the enforcement of the three years' minimum course of study in recognized medical schools before non-nationals can be admitted to the *Medical Register* of the United Kingdom, and to make representations direct to the Combined Scottish Colleges to this effect.

Conditions of Service of Prison Medical Officers

79. The Council has had under consideration the conditions of service of employment of members of the Prison Medical Service, where there are at present two classes of officers—namely:

> Class I, numbering 12 officers, whose remuneration is £791, rising by £30 per annum to £950 13s.
> Class II, numbering 15 officers, whose remuneration is £515 18s., rising by £25 per annum to £750 12s.

In addition to salary, a house is provided or a cash allowance made in lieu thereof, the allowance being calculated for superannuation purposes at £50 per annum in London and £39 per annum in the provinces. In the case of one or two prisons there are special allowances to the medical officers because of the extra duties involved.

In the ordinary course of events an officer must serve for twelve years before reaching his maximum salary in Class II, and there is no certainty, owing to the very limited size of the service, that he will be promoted when he has reached that stage. If he be promoted to Class I the most he can hope for is a salary of something under £1,000 a year, or, if the house allowance be included, just over £1,000 a year.

Although there is no maximum age for entering the service, very few officers enter before 30 years of age, in view of the demand of the Commissioners that appointments in the Prison Medical Service should be open only to practitioners with some years' experience of their profession.

A comparison of the salaries of prison medical officers with those which can be obtained in other branches of professional work, more especially when the nature of the prison medical officers' duties is taken into account, clearly indicate that the prison medical officer is underpaid.

The Council is therefore suggesting the following new rates of remuneration for prison medical officers:

> Class I: £850, rising by £50 per annum to £1,100.
> Class II: £550, rising by £25 per annum to £800.

The Council has also suggested that consideration should be given to the pension rates of these officers, in view of the fact that it is practically impossible for the prison medical officer to retire on full pension.

A memorandum upon the whole position has been prepared by the Council, and this is being submitted by the prison medical officers to the Prison Commissioners, with the statement that the representations of those officers have the full support of the Association.

Information to Insurance Companies

80. The Council has considered the following Minute 82 of the A.R.M., 1935:

> *Min. 82.*—Resolved: That the following motion be referred to the Council for consideration:
>
> 61 (2). That where any certificate is required, before or after death, in the case of a patient not previously examined for life insurance, the minimum fee should be 10s. 6d. for such certificate,

and recommends:

Recommendation: That where any medical certificate is required by an insurance company in the case of a deceased patient not previously examined for life insurance, such certificate should not be furnished without the previous consent of the relatives; and that a fee of 10s. 6d. should be paid by the insurance companies for any such certificate.

Dental Benefit Regulations—Administration of Anaesthetics

81. The provisional Dental Benefit Regulations which came into operation on January 6th, 1936, dispense with the proviso in the 1935 Regulations under which, in all cases of prolonged anaesthesia, the anaesthetist was required to be either a registered medical practitioner or a registered dentist on an approved list. Under the new Regulations, therefore, in cases of prolonged anaesthesia in dental operations, the anaesthetic may be administered by any registered medical practitioner or by any registered dentist.

The A.R.M., 1927 (Minute 83), decided that no person other than a registered medical practitioner should administer any anaesthetic for medical or surgical purposes, except that a registered dentist who has received special instruction in the administration of anaesthetics may administer anaesthetics for dental purposes. The Council therefore has made representations to the Ministry of Health that in the interests of the public the draft Regulations should be amended in order to prevent the administration of general anaesthetics by persons who have not received the necessary training.

Fees for Administration of Anaesthetics in Connexion with Dental Treatment

82. The Provisional Dental Benefit Regulations referred to above lay down the fees to be paid thereunder for the administration of general anaesthetics, as follows:—

Administration of General Anaesthetics: Fee per case in connexion with the extraction of

	s.	d.
One to four teeth...	5	0
Five to eight teeth	7	6
*Nine to twelve teeth	12	6
*Thirteen to sixteen teeth... ...	17	6
*Seventeen or more teeth	£1 1	0

* Provided that no fee in excess of 7s. 6d. shall be payable for the administration of a general anaesthetic unless a doctor or dentist (other than the dentist performing the extractions) administers the anaesthetic.

Doubt apparently exists in the minds of some medical practitioners as to their position under the above paragraph of the Regulations, and the Council therefore desires to draw the attention of members, first, to the fact that a medical practitioner may charge whatever fee he may decide upon, and, secondly, to the fact that the Annual Representative Meeting, 1927, expressed the following opinion as to the minimum fees which should be accepted by medical practitioners administering anaesthetics for dental operations as an additional benefit under the National Health Insurance Acts:—

(*a*) For the simple administration of nitrous oxide or a similar anaesthetic, 10s. 6d. if only one patient is dealt with, but if more than one patient is dealt with at the same time and place the fee should be 7s. 6d. per patient.

(*b*) For other administrations, whatever the anaesthetic, the fee should be £1 1s.

Where, at the request of a patient or dentist, a medical practitioner is called in to administer an anaesthetic in these cases, the difference between the fee to be paid under the new Regulations and the fee charged by the medical practitioner must be borne by those responsible for the engagement.

Spa Treatment for Members of Friendly Societies

83. The A.R.M., 1928, approved a scheme for the provision of spa treatment of members of friendly societies, and at the request of the British Spas Federation the Council has agreed that the wives and children of members of friendly societies should be allowed to participate in this scheme.

Central Emergency Fund

84. This fund, entirely supported by voluntary contributions, was created in 1905 with the object of assisting members of the Association by grants which cannot be made from the funds of the Association to maintain the interests of the profession, where necessary, against organized bodies.

During the past year the fund has been used for the purposes of the settlement of the Llanelly dispute. This is a striking example of the use to which a fund of this character can be put and of the need for its existence. There is an urgent need for an augmentation of the fund, and the Council strongly commends it for the support of members.

Medical and Surgical Appliances (Advertisement) Bill

85. The Medical and Surgical Appliances (Advertisement) Bill, the object of which is to "prohibit the holding out of medicines, surgical appliances, or treatment as effective in relation to certain ailments, and the publication of invitations to diagnosis, or to the treatment of certain ailments, by correspondence, and for purposes incidental thereto," was introduced into Parliament by Mr. G. A. V. Duckworth, M.P., as a private member's Bill. The Bill had the support of the Council, and represented an instalment of the policy of the Association in the matter of the control of secret remedies. The Council regrets that the measure was "talked out."

Payment of Fees under the Road Traffic Act, 1934, for Emergency Treatment

86. The Council again draws attention to the fact that the Association has prepared a model claim form and explanatory memorandum for the purpose of enabling those of its members who give medical or surgical treatment in motor accidents to claim the fee to which they are entitled under the Road Traffic Act of 1934. A pad of these forms will be supplied without cost to any member who makes application to the Medical Secretary. Doubts had arisen as to which party was responsible for the practitioner's fee in those cases where more than one vehicle is involved in an accident. The Council has been advised that a large majority of insurance companies have arranged among themselves to bear the cost on the following basis:

(*a*) Where the injured party was in or on a vehicle the cost will be borne by the insurer of that vehicle.

(*b*) Where the injured party was not in or on a vehicle the cost will be borne by the insurer of the vehicle which actually strikes him.

(*c*) In any other case the cost will be borne equally by the insurers of the vehicles involved.

It is anticipated that this simple arrangement will dispose of nearly all cases on facts which will be readily ascertainable and beyond dispute. It is therefore suggested that practitioners should be guided by the same rules in making their claims. In the infrequent cases referred to in (*c*) above, the practitioner would, of course, decide for himself against which party to claim, the adjustment being made between the insurers. At the same time it is suggested that as it is unnecessary for practitioners to claim against the users of both vehicles, they should avoid doing so, as otherwise unnecessary work would be created both for the practitioner and the insurance companies.

Workmen's Compensation and Accident Cases

87. The A.R.M., 1935 (Minute 83), expressed the view that a fee of not less than £1 1s. should be paid for examination and report on workmen's compensation and accident cases. The Council has asked the Divisions to bring this Minute to the notice of members, and has addressed a communication on the subject to those insurance companies engaging in workmen's compensation business.

Women Assistant Medical Officers Employed by the General Post Office

88. It is the long-standing policy of the Association that no distinction be made on the ground of sex as regards the amount of the emoluments to be paid to women practitioners, but for many years the Post Office declined to apply the principle of equality of salary to its women assistant medical officers.

The Council is glad to report that the Post Office has now decided to pay these officers the same basic scales as are given to male assistant medical officers.

Deaths due to Industrial Diseases of the Lungs and Blood Poisoning

89. The Sheffield Division reported to the Council some two years ago that difficulty was being experienced in the area in those cases where death was certified by the practitioner as being due to (1) fibrosis of lungs, or (2) septicaemia, occasioned by non-industrial conditions, as all such cases had to be reported to the coroner by the registrar with a view to an inquest being held. The question raised by the Division was discussed with representatives of the Registrar-General's department, and the Council has now been informed that the following instruction has been issued to registrars of births and deaths:

Deaths due to (1) *Industrial diseases of the lungs*
(2) *Blood poisoning*

In respect of deaths which are referable to coroners under Article 75 (1) (iii) of the Regulations, registrars are hereby instructed that:

(1) A death certified as due to a cause set out in Appendix H (pp. 191–2) of the Handbook as a synonym or alternative for industrial disease of the lungs would not be reported to the coroner *when it is expressly certified as non-industrial.*

(2) A death certified as due to a type of pyaemia or septicaemia or sepsis or sapraemia described as meningococcal.
or pneumococcal
or puerperal

should not be reported to the coroner on the ground that it appears as the only cause of death.

Others or unspecified types of pyaemia, septicaemia, sepsis, or sapraemia should continue to be reported when appearing as the sole cause.

Remuneration of Practitioners at Training Centres of Ministry of Labour

90. The Council has been consulted by the Ministry of Labour as to the remuneration to be paid for medical attendance upon those men in training at the Department's residential instructional centres who are not entitled to medical benefit under the National Health Insurance Acts.

The Council has agreed to the following arrangements:

(i) Each trainee to have free choice of doctor subject to (iv) below;

(ii) The practitioner to be paid the same rates as may from time to time apply in the case of insurance practitioners;

(iii) Mileage rates to be paid in addition where the chosen practitioner resides between two and five miles from the centre;

(iv) In the case of centres situated five miles or more from the nearest doctor, the Ministry to be free to make special arrangements with a view to the attendance of all trainees at the centre by one doctor, and to negotiate with him a lump sum payment which would include an allowance for mileage.

Fees for Life Insurance Examinations

91. The Council has considered the following Minute 81 of the A.R.M., 1935:

> *Min. 81.*—Resolved: That where the fee of 10s. 6d. is payable for a life insurance examination for sums of £100 or under, an abbreviated form of report should be used, and as many particulars as possible filled in by the agent of the company prior to the examination;

and has urged the adoption of an abbreviated form of medical report upon those insurance companies whose forms are open to objection. The Council has also suggested to the companies concerned that in those cases where a fee of less than £1 1s. is paid for the medical examination the company should oblige the Association by issuing a general instruction to its agents asking them to complete as many particulars as possible concerning the previous medical history of the applicant prior to the medical examination.

Coroners' Law and Practice

92. The Departmental Committee on Coroners' Law and Practice reported in February last, and the Council has noted that the majority of the recommendations submitted by the Association to that committee have been accepted.

One of the recommendations of the Departmental Committee was that only solicitors or barristers should be appointed as coroners, a point not referred to in the Association's evidence in view of the following provision of the Coroners (Amendment) Act of 1926:

> "No person shall be qualified to be appointed to be coroner for a county or a coroner of a borough or a deputy or assistant-deputy coroner unless he is a barrister, solicitor, or legally qualified medical practitioner of not less than five years' standing in his profession."

Also the report of the Departmental Committee did not deal with the Association's suggestion that there should be statutory provision for payment of a fee of not less than 10s. 6d. where a practitioner makes a report to a coroner on the medical history of a deceased patient so as to assist the coroner in coming to a decision as to whether or not it is necessary to hold an inquest.

If and when steps are taken to give legislative effect to the recommendations of the Departmental Committee on Coroners' Law and Practice, the Council will press for the adoption of the following points:

(*a*) that coroners should possess both legal and medical qualifications. Failing this, a person with medical training only should be preferred to one having a legal training only. A decision to this effect was adopted by the A.R.M., 1925.

(*b*) that there should be a statutory provision for the payment of a fee of not less than 10s. 6d. where a practitioner makes a report to a coroner on the medical history of a deceased patient so as to assist the coroner in coming to a decision as to whether or not it is necessary to hold an inquest.

Representation of Profession on Local Authorities

93. The Council has considered the following Minute 177 of the A.R.M., 1935:

> *Min. 177.*—Resolved: That the Representative Body, believing it to be of the utmost importance that medical practitioners should seek election to local authorities, instructs the Council to consider and report on the most suitable procedure for the adoption of candidates most fitted for public work and for the promotion of their candidatures;

and recommends:

> **Recommendation:** That the Representative Body believing it to be of the utmost importance that medical practitioners should seek election to local authorities, urges Divisions
>
> (*a*) to encourage members of the Association to interest themselves in local politics and to offer themselves as candidates through the recognized machinery of the area;
>
> (*b*) to give support in connexion with the election of such members of the Association as offer themselves for election and can be relied upon to support the policy of the Association on major questions;
>
> (*c*) to maintain the closest contact with the medical members of local authorities, and continually to keep them informed of the views of the Division on matters before local authorities.

If the above recommendation is approved Divisions will be advised as to the more important ways and means by which support can be given to approved candidates in local authority elections.

Departmental Committee on the Workmen's Compensation Acts

94. The Council submits in Appendix IV the Memorandum of Evidence submitted by the Association to the Departmental Committee on the Workmen's Compensation Acts on the medical questions coming within the reference of that committee (other than miners' nystagmus). This latter question is dealt with in a later para. of this report. Oral evidence in support of the views advanced in Appendix IV was given before the Departmental Commitee by Mr. R. C. Elmslie and the Medical Secretary.

Unemployed Persons and Certificates in Support of Applicants for Medical Extras

95. Representations were made to the Unemployment Assistance Board for the payment of a fee for the medical certificate which the Board required of applicants for medical extras in support of their claim. The Council is advised that, although the Board takes a broad view of its powers and recognizes a responsibility for placing its applicants in a position to meet the expense of diet required by the specific pathological condition from which some members of their household dependent upon them is suffering, the Board has no statutory power to pay a fee for a medical certificate in support of a claim for medical extras. In such cases, therefore, the Board would, if a fee was demanded for this service, have to consider the question of referring all such applicants to the Poor Law authorities, in order that the certificates might be furnished by district medical officers.

Although the Council feels that a fee should be paid for these certificates it is of opinion, in view of the considerations stated above, that it would be inappropriate at the present time to press for the payment of a fee.

Compulsory Use of Yellow Lights on Motor Cars

96. The Minister of Transport (*a*) forwarded to the Association a report by a committee of the French Ministry of Public Works which had recommended to the French Government that the use of yellow lights in motor car headlights should be made compulsory, and (*b*) asked the Association to examine the questions raised by the French report and to let him have its observations thereon.

A special committee, set up under the chairmanship of Professor Sir Joseph Barcroft, considered the matter and drew up the report appearing in Appendix V. The Council forwarded a copy of the special committee's report to the Minister of Transport, who expressed his appreciation of the trouble which the Association had taken in the matter and stated that the committee's report would be most valuable.

REPRESENTATION OF PROFESSION IN PARLIAMENT

97. The Council has reviewed the steps at present taken by the Association which have for their object the election to Parliament of persons possessing expert knowledge upon matters relating to the health of the community and which involve the welfare of the medical profession. Reference is made in a later section of this report to the action taken at the recent General Election in regard to the representation of the profession in Parliament, but the Council, after consideration of this matter in all its aspects, has come to the conclusion that steps should be taken to supplement the existing machinery. The Council recommends:

Recommendation: That, with a view to ensuring the presentation to Parliament of expert medical opinion on matters relating to the health of the community or involving the welfare of the medical profession, the Representative Body approve the principle of securing the services of a Member of Parliament intimately acquainted with the aims and policy of the British Medical Association.

Recommendation: That the above decision be implemented by appointing a person elected to Parliament to an official post in the Association.

Recommendation: That steps be taken forthwith to make preliminary inquiries for the selection of a medical practitioner intimately acquainted with the aims and policy of the Association, with a view to his election to Parliament through one of the University seats.

PUBLIC HEALTH

Co-ordination of Policies Relating to Medical Practitioners Employed Part-time by Local Authorities

98. At various times the Association has adopted policies regarding the remuneration and conditions of service of medical practitioners employed part-time by local authorities. These are listed, with references to the pages of the Association's 1935–6 *Handbook*, below:

(*a*) Fee for ante-natal and post-natal examinations—contained in para. 43 of the Memorandum outlining a National Maternity Service Scheme for England and Wales, approved by the A.R.M., 1929:

namely—

For ante-natal examination and report ... 10s.
For each subsequent attendance ... ... 5s.
(Or a capitation fee of 11s. 6d.)
For post-natal consultation and report ... 5s.

(*b*) Fee for medical certificates under Blind Persons Act (A.R.M., 1928, Min. 113; and A.R.M., 1935, Min. 99) pp. 88 and 89 of *Annual Handbook*.

(*c*) Consultations and operations (A.R.M., 1926, Mins. 66 and 95)—namely:

For consultant not less than ... ... £3 3s.
For a major operation not less than ... £10 10s.

(*d*) Part-time consultant members of Visiting Staffs of Council Hospitals (A.R.M., 1932, Min. 57)—pp. 106–8 of *Annual Handbook*.

(*e*) Part-time work in treatment of school children and maternity and child welfare (A.R.M., 1923, Min. 146)—p. 111 of *Annual Handbook*.

(*f*) Orthopaedic hospitals and clinics and treatment of physically crippled children (A.R.M., 1926, Min. 103)—p. 116 of *Annual Handbook*.

(*g*) *X*-ray diagnosis and treatment of tuberculous cases referred to hospitals by local authorities (A.R.M., 1921, Min. 268)—p. 131 of *Annual Handbook*.

(*h*) Vaccination by session (A.R.M., 1920, Min. 194)—p. 129 of *Annual Handbook*.

(*i*) Venereal Diseases Medical Officers in connexion with local schemes (A.R.M., 1917, Min. 97, and A.R.M., 1923, Min. 147)—p. 132 of *Annual Handbook*.

The Council has thought it desirable to co-ordinate and consolidate these policies, with minor modifications, in the manner set out in the following recommendations:

Recommendation: That the following be adopted in substitution for the existing policies of the Association in regard to the remuneration of medical practitioners employed part-time by local authorities:

A. Remuneration on a Sessional Basis

(1) MATERNITY AND CHILD WELFARE; DIPHTHERIA IMMUNIZATION

For the medical care of infants; for the ante-natal or post-natal care of pregnant women; for the medical inspection of school children; for the treatment of minor ailments; for diphtheria immunization.

Remuneration at the rate of £1 11s. 6d. per session of not more than two hours.

(2) CONSULTANT AND SPECIALIST WORK AT HOSPITALS OR CLINICS

For consultant and specialist work at hospitals or clinics (including the administration of anaesthetics, treatment of venereal disease, and *x*-ray examination and treatment), remuneration on the following scale:

Regular Sessions

(*a*) Where the method of payment is by salary then:

	Not less than £
Where not more than 1 regular attendance or session per week is required of not more than 2 hours' duration ..	125 p.a.
Where 2 regular attendances or sessions per week are required	200 p.a.
Where 3 regular attendances or sessions per week are required	275 p.a.
Where 4 regular attendances or sessions per week are required	350 p.a.
Where 5 regular attendances or sessions per week are required	425 p.a.
Where 6 regular attendances or sessions per week are required	500 p.a.

Indivdual Sessional Fees

(*b*) Where an indivdual, additional, or occasional consultative, or specialist session of not more than two hours' duration is required, the remuneration should be not less than £2 12s. 6d. per session.

Emergencies

(*c*) If emergency attendances are required the fee should bear suitable relation to the ordinary fees of the area for the service given, and should be arranged after consultation with the local profession.

Mileage

(*d*) In every case an augmentation of salary or a suitable payment for mileage should be arranged, except when the practitioner's residence or consulting room is within two miles of the institution where the attendance or services are rendered.

Holidays

(*e*) Consultants employed at an annual salary should be allowed a reasonable annual holiday for which period of absence from duty locumtenents should be provided at the expense of the local authority.

(3) EXAMINATION AND CERTIFICATION OF THE BLIND

For examination and certification of the blind, remuneration should be not less than £3 3s. for a session of two hours.

(4) OPHTHALMIC WORK

For ophthalmic work involving refractions, 10s. 6d. per case, or £2 12s. 6d. per session of not more than two hours, provided there is limitation, to be agreed locally, of the average number of new cases to be seen in each session.

(5) ADENOID AND TONSIL OPERATIONS

For adenoid and tonsil operations involving a general anaesthetic, a total fee for the two practitioners concerned of £1 11s. 6d. per case for less than four cases; or £5 5s. per session at which the average number of cases per session to be dealt with is agreed locally, such agreed number to be not more than eight.

B. Remuneration on a Payment per Case Basis

(6) ANTE-NATAL AND POST-NATAL EXAMINATIONS

Ante-natal or post-natal examinations:

5s. for each ante-natal or post-natal examination.
5s. per case for a report to the local authority, if requested by the local authority.

(7) X-RAY TREATMENT OF RINGWORM

X-ray treatment of ringworm: £3 3s. per completed case where the practitioner provides his own apparatus, or £2 2s. where the apparatus is provided by the local authority.

(8) BLIND PERSONS ACT

Blind Persons Act: for medical certificates of blindness for any of the following purposes not less than 1 guinea:

(*a*) to support a claim for a pension under the Blind Persons Act, 1920; or

(*b*) to support an application in respect of a blind person by a local authority or voluntary agency for grant out of public funds under the regulations for the welfare of the blind, or under the Education Committee; or

(*c*) to obtain evidence of blindness before the registration of a blind person.

(9) GENERAL ANAESTHETICS

General Anaesthetics:

Simple administration of nitrous oxide or similar anaesthetic, if only one patient	10s. 6d.
Simple administration of nitrous oxide or similar anaesthetic, if more than one patient dealt with at same time and place	7s. 6d. per patient.
Other administrations, whatever anaesthetic, not less than	£1 1s. 0d.

(10) SURGICAL OPERATIONS

Surgical operations (other than those referred to in para. (5):

Minimum fee for each operation ..	£5 5s. 0d.
Minimum fee for major operation ..	£10 10s. 0d.

(11) CONSULTATIONS

Consultations: £2 2s. 0d. plus mileage.

[A suggested scale of fees, including mileage, is as follows:

£3 3s. 0d. up to 5 miles
£4 4s. 0d. 5 to 10 ,,
£5 5s. 0d. 10 to 15 ,,
£6 6s. 0d. 15 miles or over.]

(12) IMMUNIZATION FOR DIPHTHERIA

Not less than 7s. 6d. per immunized person, the local authority supplying the materials.

For services not mentioned above, the rate of remuneration should be arranged after consultation with the local profession.

SIR CHARLES HASTINGS LECTURE, 1936

99. The eighth Sir Charles Hastings Lecture to the general public was delivered under the chairmanship of Dr. Adolphe Abrahams, O.B.E., Dean and Lecturer in Medicine at the Westminster Hospital Medical School and Consulting Medical Adviser to the British Olympic Athletic Team, by Winifred Cullis, C.B.E., D.Sc., LL.D., Professor of Physiology, University of London, and R. Cove-Smith, M.B., M.R.C.P., D.P.H., Physician-in-charge, Rheumatism Clinic of Hospital for Sick Children, Great Ormond Street, London, W.C.1, on Tuesday, March 10th, 1936, the subject being "Keeping Fit." The attendance was 600, and a résumé of the lecture appeared in the *British Medical Journal* of March 21st, 1936, pp. 595–7.

ALLOCATION TO SCHOOL M.O's., TEACHERS, AND SCHOOL NURSES OF VARIOUS DUTIES IN CONNEXION WITH THE MEDICAL INSPECTION AND TREATMENT OF SCHOOL CHILDREN: AGREEMENT BETWEEN NATIONAL UNION OF TEACHERS AND B.M.A., 1915

100. In 1915 the A.R.M. approved a memorandum on the allocation to school medical officers, teachers, and school nurses of various duties in connexion with the medical inspection and treatment of school children. The National Union of Teachers issued copies to school teachers and the Association issued copies to school medical officers. Recently the National Union of Teachers reported that, as the terms of the memorandum did not appear to be widely known, it had reissued the memorandum, and it requested that the Association should also reissue it. The memorandum was published in the *B.M.J. Supplement* of December 14th, 1935, with an indication that further copies were available on application.

PROVISION OF MEALS FOR CHILDREN ATTENDING PUBLIC ELEMENTARY SCHOOLS

101. In September, 1934, the Board of Education issued to local education authorities a circular (No. 1437) headed "Provision of Milk for School Children" and the Council informed the Board of Education:

(*a*) that whilst it was desirable that all children receiving milk or meals free of charge should be under medical supervision and that all children found at medical inspections or surveys to be of subnormal nutrition should be eligible for free milk or meals on medical recommendation, if the parents were unable to defray the cost the Association was of opinion that the onus should not be placed upon a medical officer of determining in every case that a scholar was presenting evidence of subnormal nutrition as a condition for the provision of free milk or meals;

(*b*) that, notwithstanding the suggestion implicit in the Board's circular (that the selection of children, unable by lack of food to take full advantage of the education provided for them, for free meals was undertaken by the medical officers of local authorities) the Association understood that this method of selection was not generally in operation.

On December 16th, 1935, the Board of Education issued Circular 1443 in which it was stated that discussions with local education authorities had made it evident that a restatement of the Board's attitude would be of assistance in making clear the objects in view. In the circular it was suggested that authorities should "take steps to ascertain the children who are in need of feeding by inviting reports from members of the School Medical Service, or the Public Health Service, from teachers, school nurses, school attendance officers, and others in regular contact with the children from day to day," and that "children should be seen as soon as possible by the School Medical Officer." The Council regards this restatement as a substantial advance upon that of Circular 1437.

NATIONAL MATERNITY SERVICE

(*a*) *Association's Memorandum on a National Maternity Service for England and Wales*

102. A special committee was appointed by the Council to reconsider the Association's Memorandum outlining a National Maternity Service for England and Wales approved by the A.R.M., 1929, and, as part of this recon-

sideration, to examine the Report of the Joint Council of Midwifery.

The following resolutions of the Annual Representative Meeting, 1935, were considered, Minute 115 being incorporated in the Memorandum submitted by the Council in the recommendation set out below:

Min. 114.—Resolved: That (with reference to para. 106 of the Annual Report of the Council) in view of the serious diminution of the opportunities for midwifery in general practice, the Council be asked to consider the whole matter and report on it at the earliest opportunity.

Min. 115.—Resolved: That the British Medical Association regrets that the question of maternal mortality has become the subject of widespread political discussion, receiving great publicity in the lay press. Maternal mortality is a scientific and administrative problem which deserves careful and scientific study, but, in the experience of practising doctors, the publicity which it is receiving to-day is tending to terrify child-bearing women and is, in itself, a cause of increased mortality.

In view of possible legislation the Council considered it advisable that the views of the Association should be made known at the earliest possible date, and the memorandum was published in the *B.M.J. Supplement* of December 7th, 1935. Copies were sent to the Ministry of Health, Maternal Mortality Commitee, British College of Obstetricians and Gynaecologists, Society of Medical Officers of Health, Association of County Medical Officers of Health, Association of Inspectors of Midwives, Midwives' Institute, Queen's Institute of District Nursing, College of Nursing, National Birthday Trust Fund, British Hospitals Association, County Councils Association, Association of Municipal Corporations and Urban District Councils Association.

Recommendation: That the Memorandum regarding a National Maternity Service (Appendix VI) be approved.

(b) Report of the Joint Council of Midwifery

103. The Report of the Joint Council of Midwifery in which was advocated the establishment of a municipal salaried midwives' service in areas not adequately served by salaried midwives was considered by the Council.

104. The Council approved the following memorandum, copies of which were sent to the Ministry of Health, the Joint Council of Midwifery, and the Midwives Institute:—

The Council of the British Medical Association desires to comment briefly upon the proposals recently made by the Joint Council of Midwifery and referred by the Minister of Health to associations representing local authorities.

Among the recommendations of the Joint Council of Midwifery are the following:

(3) That a salaried Midwives' Service should be established under the appropriate local authority in all areas not already served by salaried midwives. It is not intended to interefere with the continuance in practice of independent midwives.

(4) That it should be the duty of every appropriate local authority to provide or secure the provision of an adequate domiciliary service of midwives in its area, and for this purpose:

(*a*) to employ the requisite number of whole-time midwives at adequate salaries, and/or

(*b*) to aid approved voluntary organizations (including provident societies) that employ salaried midwives for service in its area.

(7) That before initiating a scheme for its area the local supervising authority should consult with representatives of the hospitals, nursing associations, and other voluntary organizations which are concerned in maintaining a salaried service of midwives, of the local Midwives' Association, and of the medical practitioners of the area, with the following objects:

(*a*) to provide effectively for the needs of the area;

(*b*) to avoid duplication of service in any part of the area;

(*c*) to ensure substantial equality in rates of pay and conditions of service among the salaried midwives in the area;

(*d*) to settle the fees to be charged for the services of municipal midwives, whether acting as midwives or maternity nurses.

The medical profession is interested more in the efficiency of a midwives' service than in the method of securing it. If the general principle involved in the proposal to conduct midwifery through whole-time midwives, in cases where no other arrangements are possible—which appears to be acceptable to the Midwives' Institute—is adopted, certain conditions should be regarded as essential. Any scheme should ensure:

(i) that there should be as free a choice as possible of midwife by patient;

(ii) that in the case of individual midwives, skill, judgement, and personality should reap their reward; and

(iii) that the medical practitioner should have the opportunity of advising his patient as to the midwife who will share with him the responsibility for that patient's welfare.

Administratively such arrangements may be more difficult in connexion with a municipal service than under the more elastic methods of a voluntary organization.

The proposals of the Joint Council, if adopted, would involve serious disturbance and, in many areas, the practical abolition of private practice by midwives. The Joint Council proposes that any private midwives who apply for admission into the salaried service but are not accepted should receive compensation. The Association recognizes that the private practice of midwives is complicated by the large number of women who qualify but attend only occasional cases, and whose main occupation is entirely unconnected with nursing or midwifery, and is in sympathy with any fair means of eliminating such forms of practice. In the Association's view no scheme should receive the approval of the medical profession unless it provides for adequate compensation to those displaced.

The most serious criticism the Association has to make is that the introduction of a purely municipal service in some areas and the making of a grant from public funds in others may seriously affect the funds of those voluntary associations which are doing such good work in many parts of the country. Further, the Association feels strongly that nothing should be done which would tend to diminish the number of domiciliary cases required for training medical students and midwives.

The Association would urge the establishment of permanent machinery to secure that, in developing midwives' service, local authorities shall consult the local medical profession, midwives, training hospitals, voluntary associations, and any other bodies having a direct interest in the matter.

(*c*) A deputation from the Association discussed with representatives of the Ministry of Health the recommendations contained in the Report of the Joint Council of Midwifery on the desirability of establishing a salaried service of midwives. The deputation:

(i) informed the Ministry that the Association regretted that it was not proposed to legislate now on the larger problem of a National Maternity Service on the basis of the Association's proposals, and

(ii) drew attention to the Association's Memorandum relating to the Report of the Joint Council of Midwifery and to the absence of proposals to deal with the midwife, part of whose time is spent in non-nursing occupation, and to exercise the power to make regulations regarding the qualifications of midwives employed by local authorities.

(*d*) A deputation to the Ministry of Health emphasized the desirability of the consideration by the Government of the problem of a National Maternity Service as a whole and not in separate stages, except in so far as parliamentary considerations rendered it inevitable. The principles of the Association's policy were advocated as essential to any national service conceived and administered in the public interest. The Minister promised the most careful consideration of the Association's proposals.

(*e*) Since the introduction into Parliament of the Government's Midwives Bill, the attention of the Medical Committee in the House of Commons has been drawn to the Association's vews on the Bill and to the Association's proposals regarding a National Maternity Service.

(*f*) A reasoned statement of the case for a National Maternity Service on the lines of the Association's proposals has been circulated to the Press, to members of Parliament, and to maternity and child welfare authorities in England and Wales.

ANTE-NATAL EXAMINATIONS BY GENERAL PRACTITIONERS

Fees

105. In the Association's Memorandum outlining a National Maternity Service Scheme for England and Wales, approved by the A.R.M., 1929, the Association suggested that the fee for ante-natal examination and report should be 10s., and for each subsequent attendance 5s., or a capitation fee of 11s. 6d.

It having been learned that the Ministry had informed local authorities which had made inquiries that it considered 5s. to be an adequate fee for an ante-natal examination and report, the subject was discussed with representatives of the Ministry, who stated that they based their action on the following paragraph in the Report of the Royal Commission on National Health Insurance, 1926:

> 337. The average number of confinements in respect of which maternity benefit is payable is estimated to be 717,500 per annum, of which 517,500 are cases of uninsured women. The first of the new requirements would seem to be provision for medical examination, ante-natal and post-natal. An outside fee for these examinations would be 5s. each (10s. in all). . . .

The Association's representatives informed the Ministry that the grounds of this decision appeared to be entirely inadequate, and urged reconsideration. Subsequently, the Ministry of Health wrote as follows:

> " . . . The conclusion we have reached is that if a local authority in future propose to pay 2s. 6d. for the report by an insurance practitioner on his ante-natal examination of an insured woman, we should not object to the payment of 2s. 6d. for a similar report in the case of an uninsured woman, in addition to the fee of 5s. for the examination itself."

This information was communicated to Division and/or Branch Secretaries and medical officers of health in areas where general practitioner ante-natal examination schemes were in operation.

ANTE-NATAL SCHEMES

106. Advice, according to the policy of the Association, has been given in respect of a number of projected ante-natal general practitioner schemes, and several satisfactory schemes have been adopted during the session—namely, in Buckinghamshire, Gloucestershire, and Oxfordshire, and in Cambridge and West Hartlepool. Schemes are under consideration in Berkshire, East Suffolk, and West Suffolk.

FEES TO MEDICAL PRACTITIONERS UNDER SECTION 14 OF MIDWIVES ACT, 1918

107. Following the judgement given in the Court of Appeal in the case of Brown and others *v.* the Monmouthshire County Council, and the County Council having decided not to appeal, the Minister of Health issued a circular stating that he was advised that para. 8 of the scale of fees, see below, was *ultra vires* and must therefore be regarded as deleted:

> Para. 8. No fee shall be payable by the local supervising authority:
>
> (1) Where the doctor has agreed to attend the patient under arrangement made by or on behalf of the patient or by any club, medical institute, or other association of which the patient or her husband is a member, or when the doctor is under obligation to give the treatment to the patient under the National Health Insurance Acts, 1911 to 1922.
>
> (2) Where the doctor receives or agrees to receive a fee from the patient or her representative.
>
> (3) In respect of any services performed by the doctor on any date later than the tenth day from the date of his first attendance unless he has reported to the local supervising authority that he considers, for reasons stated by him, that his further attendance is necessary, or in respect of any services performed by the doctor after the expiry of four weeks from the day of birth.

The Midwives Bill now before Parliament empowers the Minister to lay down conditions for the payment of fees under Section 14 of the Midwives Act, 1918.

In 1930 the Annual Representative Meeting adopted a scale of fees for medical practitioners called in on the advice of midwives (pp. 111 and 112 of the Association's *Handbook*, 1935-6). In June, 1931, a deputation from the Association discussed this matter with representatives of the Ministry of Health, but it was agreed not to press for a revision of the scale of fees at that time owing to the prevailing financial stringency. A deputation from the Association recently discussed this matter with the Ministry of Health, and the Council hopes to be in a position to report in its Supplementary Annual Report.

IMMUNIZATION INCLUDING VACCINATION

108. A copy of the following resolution of the A.R.M., 1935, was sent to the Ministry of Health:

> *Min. 108.*—Resolved: That the Ministry of Health and local authorities be urged to secure the establishment of adequate machinery for the collection and storage of convalescent serum for use in prophylactic measures against measles.

In accordance with the following resolution of the A.R.M., 1935, a copy of the Report on Immunization including Vaccination was sent to the Divisions:

> *Min. 109.*—Resolved: That this meeting welcomes the Report on Immunization including Vaccination, as a clear and valuable statement of the methods which may be adopted in the public interest for the control of certain diseases, and recommends the Council to keep the matter under review and to forward the Report to the several Divisions in order that each may consider the recommendation in relation to local conditions and their applicability therein.

ADDITIONAL DUTIES PLACED ON MEDICAL OFFICERS OF HEALTH

109. The question of " additional " duties imposed on medical officers of health is receiving very careful attention, and an opportunity is being sought of discussing the matter with the Ministry of Health.

ORGANIZATION OF MENTAL HEALTH SERVICES

109A. A conference between representatives of the Association and representatives of the Royal Medico-Psychological Association in regard to the organization of mental health services arrived at the following conclusions. Action has been deferred pending further representations by the Royal Medico-Psychological Association:

> (*a*) That local authorities should be encouraged to form Mental Health Committees to deal with lunacy and mental deficiency.
>
> (*b*) That each local authority responsible for mental health should be advised by a medical officer with adequate experience of mental work, who may be a medical superintendent of one of the authority's institutions, subject to the administrative position of the medical officer of health and to the right of the medical superintendent to be present and to express his views at meetings at which matters intimately affecting his institution are under consideration.
>
> (*c*) That adequate medical presentation to the Mental Health Committee of the specialized needs of both mental disorders and mental deficiency is necessary.

EDUCATION OF THE PUBLIC IN HEALTH MATTERS

110. The A.R.M. in 1927 approved a Memorandum as to action which could be taken by Divisions and Branches in relation to the education of the public in health matters. This Memorandum has been recirculated to Branches and Divisions in Great Britain and Northern Ireland, and to Public Medical Services.

PUBLIC ASSISTANCE DOMICILIARY MEDICAL ATTENDANCE

111. The preparation of a model public assistance domiciliary medical service scheme is under consideration. Advice, according to the policy of the Association, has been given in respect of projected schemes, and since the last Annual Representative Meeting the Carnarvonshire and Lindsey County Councils and the Croydon County Borough have adopted such schemes. Schemes are under consideration in Ayrshire, Clydebank, Gloucestershire (Forest of Dean), Lincoln, Manchester, Monmouthshire, Sunderland, and Wolverhampton.

MEMORANDUM OF RECOMMENDATIONS AS TO SALARIES OF WHOLE-TIME PUBLIC HEALTH MEDICAL OFFICERS

112. The Association again acknowledges with gratitude the continued co-operation of the Society of Medical Officers of Health and of the proprietors of the *Lancet* and the *Medical Officer* in rejecting advertisements from authorities which have not applied the Memorandum of Recommendations scales to their whole-time public health medical officers. The Advisory Committee, set up under Section X of the Memorandum, has dealt with several cases during the year.

The attitude of local authorities to the Memorandum of Recommendations is in the main satisfactory and there are now few important authorities not applying this Agreement. Amongst the authorities which have adopted or applied the provisions of the Memorandum during the year are the Counties of Denbigh, Hereford, Northumberland, Norfolk, North Riding of Yorkshire, and East Suffolk ; the County Boroughs of Barnsley, Bradford, Middlesbrough, and Salford ; and the Metropolitan Borough of Fulham.

"MEMORANDUM OF RECOMMENDATIONS" AND SCHOOL AUTHORITIES

113. The Council has agreed that where an Education Committee is applying memorandum standards to the medical officers in the School Medical Service, its advertisements shall not be refused on the ground that memorandum standards are not being applied to the medical officers of the local authority not engaged in school medical work, provided that the Education Committee has had delegated to it, under Section 4 of the Education Act, 1921, power to appoint its officials and to determine their salaries.

MILK (SPECIAL DESIGNATIONS) ORDER, 1936

114. The draft dated January 24th, 1936, of the Milk (Special Designations) Order, 1936, proposed to be made by the Minister under Section 3 of the Milk and Dairies (Amendment) Act, 1922, has been considered. This draft Order provides that the special designations which may be used in relation to milk are "Tuberculin Tested," "Accredited," "Certified (Pasteurized)," and "Pasteurized."

In respect of "Accredited" milk, the following are among the conditions which apply to producers:

(*a*) Every milch cow belonging to the herd shall be submitted to an examination once in every three months, and the veterinary surgeon's certificates of all examinations shall be sent to the licensing authority within seven days after the dates of such certificates.

(*b*) Where an animal is certified as showing evidence of any disease which is likely to affect the milk injuriously it shall be isolated or removed from the herd. . . .

(*c*) The herd shall not at any time contain any animal which to the knowledge of the producer had before its introduction into the herd been tested with tuberculin and had re-acted to the test.

The Ministry of Health has been informed that the proposals contained in the draft Milk (Special Designations) Order, 1936, in regard to "Accredited" milk are regarded as unsatisfactory as their adoption will not assure safety to the public.

PUBLIC HEALTH BILL

115. The second interim report of the Local Government and Public Health Consolidation Committee and the draft Public Health Bill have been considered, and, in reply to the invitation of the Ministry of Health, the Council has commented upon the draft Bill.

NATIONAL HEALTH INSURANCE

H. G. DAIN

116. H. G. Dain, having retired from the chair of the Insurance Acts Committee, the Council accorded its very best thanks to Dr. Dain for the outstanding services he had rendered to the Association and the profession during the eleven years he had occupied the chair of the Insurance Acts Committee.

EXTENSION OF MEDICAL BENEFIT UNDER NATIONAL HEALTH INSURANCE

117. In connexion with the following Minute 120 of the Annual Representative Meeting, 1935:—

> *Min. 120.*—Resolved: That (with reference to para. 114 of the Annual Report of Council) while agreeing with the principle of the provision of expert medical advice and treatment and laboratory service to supplement and render more effective general practitioner service for insured persons, it is submitted that any such scheme should be initiated and administered in collaboration with the representatives of insurance practitioners.

The Council accepted an invitation to take part in an informal consultation with representatives of approved societies and insurance committees upon the question of the provision of expert medical advice and treatment and a laboratory service to supplement and render more effective the insurance practitioner service for insured persons. This conference passed the following four resolutions:

(*a*) That this conference is strongly of the opinion that the addition of consultants and specialists and laboratory services to the benefits available under the National Health Insurance Acts is one of the utmost importance, and appoints a committee to bring forward suggestions for the provision of these services.

(*b*) That the committee should consist of eighteen members, each of the three parties concerned (approved societies, insurance committees, and the medical profession) in the conference to appoint six members.

(*c*) That the conference accepts with pleasure the offer of the Chairman of the B.M.A. Council for his Association to furnish any necessary accommodation and secretarial assistance for the work of the committee.

(*d*) That Dr. H. G. Dain act as chairman of the committee.

The further invitation to appoint representatives upon the joint committee has been accepted.

"MEDICAL INSURANCE PRACTICE"

118. The Trustees of the National Insurance Defence Trust have authorized the publication of a new edition of *Medical Insurance Practice* as soon as the new Medical Benefit Consolidated Regulations are issued, and have accepted an estimate for the printing of 5,000 copies.

CHAIRMANSHIP OF COMMITTEE

119. In view of the special position of the Insurance Acts Committee as the Executive of the Panel Conference, recognized by the Ministry of Health as the central mouthpiece of insurance practitioners, the Council is of opinion that it should be possible for any member of the Committee to secure election as Chairman even though not a member of the Council. In such an event, the Committee would desire to appoint as Deputy-Chairman a member of the Committee who was a member of Council. The necessary alterations of the By-laws are dealt with under the "Organization" section of this Report.

OPHTHALMIC

NATIONAL EYE SERVICE

(National Ophthalmic Treatment Board)

120. The National Eye Service has now earned the right to take its place permanently amongst the national health services of the country. Inaugurated in 1929, it has stood the test of criticism and is regarded as a satisfactory means of providing a comprehensive ophthalmic service, including an expert medical examination, for those who are unable, financially, to make ordinary private arrangements.

The popularity of the Service is increasing rapidly, and this is evidenced by a 20 per cent. increase in the number of cases dealt with during 1935. In the administration of ophthalmic benefit under the National Health Insurance Acts, approved societies are making increasing use of it, and an interesting feature of last year's figures was the marked increase (35 per cent.) in the number of uninsured persons who availed themselves of it. It cannot be denied that the majority of these people would otherwise have presented themselves at the out-patient department of eye hospitals or would have gone to sight-testing opticians.

There have been several attempts to imitate the Service by organizations which have adopted a similar title and have endeavoured to enlist the co-operation of ophthalmic surgeons in various parts of the country. There is good reason to believe, however, that these efforts have not met with success.

The Council wishes again to emphasize the need for greater co-operation on the part of general practitioners. Despite the progress the Service is making there is no doubt that the percentage of those making use of it is not as high as it would be if practitioners would always advise those of their patients who have errors of refraction, or some other eye condition, to seek advice from a qualified oculist.

In the Council's last Annual Report particulars were given of records kept by ophthalmic surgeons of the eye conditions of some 10,000 cases referred through the National Eye Service. The investigation arose from a desire to obtain detailed information of the conditions found in an average sample of patients all over the country. The publication of these figures aroused considerable interest, because it was shown that some 35 per cent. of the patients had some defect needing medical attention over and above an error of refraction, whereas it had been stated previously by the organized body of sight-testing opticians that 5 per cent. was the appropriate figure. Records of a further 10,000 cases have since been collected by a larger number of ophthalmic surgeons, and it will be seen from the following statement that there is a remarkable similarity in the two series, thus confirming the conclusions drawn from the first series. It should be emphasized that all the 20,000 cases were entirely unselected, and consisted of every National Eye Service patient examined by those who supplied the records:

	1934 (First series) per cent.	1935 (Second series) per cent.
Cases of error of refraction only	64.09	64.22
Cases of error of refraction plus one or more "other eye conditions"	29.15	27.88
Cases without an error of refraction but with one or more "other eye conditions" ...	5.75	7.36
Cases with no appreciable eye defect ...	1.00	0.54

A more detailed analysis of the eye conditions referred to, with some observations by the chairman of the Association's Ophthalmic Committee, will be found in the *B.M.J. Supplement* of February 15th, 1936.

OPHTHALMIC SURGEONS AND HOSPITAL CONTRIBUTORY SCHEMES

121. The essence of any hospital contributory scheme should be the provision of services which can be rendered only at a hospital. The rules of some contributory schemes are drawn much wider, however, with the result that increased demands are made on the services of the honorary medical staff. This applies particularly to visiting ophthalmic surgeons, whose services are in popular demand for general eye examinations, and the situation has given rise to some anxiety in certain areas. It will be appreciated that if all the members of a scheme, *qua* members of that scheme, are to be allowed to have gratuitous ophthalmic examinations at the hospital, the position of the visiting ophthalmic surgeon is likely to become intolerable. In some contributory schemes there is provision for the exclusion of patients who are able to obtain an ophthalmic examination by other means—for example, National Health Insurance Ophthalmic Benefit—but in others much pressure on the part of the medical staff has been necessary before a provision of this nature has been secured. In their own interests, therefore the visiting staffs of hospitals are advised to watch carefully the development of contributory schemes, with a view to safeguarding themselves against unfair demands on their gratuitous services.

CERTIFICATION OF BLINDNESS—FEES FOR DOMICILIARY VISIT AND EXAMINATION

122. Upon comparatively rare occasions it is necessary for an examination in connexion with an application for registration under the Blind Persons Act to be conducted at the patient's house, but the question of the remuneration of the ophthalmic surgeon for such a service has not hitherto been raised. A city council, however, desiring to enter into an arrangement with the county council for the examination, under the city council's scheme, of all applicants within the county, wished to make provision for domiciliary visits, where necessary. Local agreement failed, and the matter was referred to the Association for guidance with a view to a decision being reached which could be applied to all areas in which a similar question may arise.

The Council recommends:

Recommendation: That the fee for the domiciliary examination of a person under the Blind Persons Act should be: (*a*) within two miles of the ophthalmic surgeon's consulting room—not less than two guineas; and (*b*) beyond two miles—not less than three guineas plus mileage both ways at the rate of one shilling per mile.

HOSPITALS

STATUTORY AUTHORITY RADIOLOGICAL CASES REFERRED TO VOLUNTARY HOSPITALS

123. During the past few months several members of the Association who are engaged in radiological practice have sought the opinion of the head office as to the charge which should be made by them for local authority radiological cases referred to voluntary hospitals. Paragraph 6, Appendix G, of the Hospital Policy, is as follows:

"6. Radiological services for statutory authorities (for example, Ministry of Health, national health insurance, municipal bodies, etc.) should ordinarily be arranged to be supplied in private by private practitioners. Where such arrangements must be made with a hospital the fees payable for the services shall be upon a scale made upon the advice of the visiting radiologist."

It appears that this paragraph needs amplification. After discussion with representatives of the British Institute of Radiology and the British Association of Radiologists, a scale of fees for radiological cases referred by statutory authorities to voluntary hospitals has been prepared for the guidance of the office in dealing with this matter.

The Council submits for the approval of the Representative Body the necessary consequential alteration of paragraph 6, Appendix G, of the Hospital Policy.

Recommendation: That paragraph 6, Appendix G, "Provision of Radiological Services" of the Hospital Policy of the Association be amended to read as follows:

"6. Radiological services for statutory authorities (for example, Ministry of Health, national health insurance, municipal bodies, etc.) should ordinarily be arranged to be supplied in private by private practitioners. Where such arrangements must be made with a hospital the fees payable for the service shall be upon a scale approved by the Association. The radiologist's report shall be given in every case. Of the fee paid not less than two-thirds should go to the radiologist for his opinion, and the remainder to the hospital to cover costs."

Constitution of Hospitals Committee

124. It is essential that there should be represented in the membership of the Hospitals Committee all branches of hospital practice, together with adequate representation of the general practitioner. As at present constituted, the Committee consists of the ex-officio members, five members appointed by the Representative Body, and five by the Council; with a view to maintaining a balance of the interests concerned in the work of the Committee it is empowered to co-opt two additional members. The Council is of opinion that there should be provision for inter-representation between the Public Health and Hospitals Committees, the work of which is in some aspects closely related, and that it should be made possible for the Committee, by increased power of co-option, to secure representation of any particular class of experience not otherwise represented. It proposes also that a seat on the Committee should be given to the Medical Superintendents' Society, which represents a section of hospital practice of growing importance as a result of the Local Government Act, 1929. This body offers, in return for this representation, to hand over to the Association the control of its medico-political activities. As a reciprocal part of the arrangement the Medical Superintendents' Society is being asked to give the Association a seat on its Council.

The Council submits in the Organization Section of this Report amendments of the Schedule to the By-laws relating to the Hospitals Committee to give effect to these changes.

Model Hospital Letter for Use by Hospitals

125. The A.R.M., 1935, approved a model letter for use by hospitals in communicating with the attending practitioner in those cases where a patient attends at a hospital without a note of introduction from a medical practitioner, and directed that steps should be taken to make available a supply of these forms to hospitals. The Council has accordingly arranged the printing of the model hospital letter in booklets of 50 and has issued a copy of the booklet to the principal hospitals in England and Wales with an indication of its belief that the booklets will prove to be of great convenience to members of hospital staffs and hospital administrators generally, and its hope that they will be freely used in hospital casualty and out-patient departments.

International Hospital Association

126. There has recently been formed an International Hospital Association whose principal objects are:

(1) To establish and maintain exchange of experience between Government Departments, National Hospital Associations, and all other associations or individuals interested in hospital activities;

(2) To establish an international bureau for the purpose of collecting literature relating to hospital matters, such literature to include important reports, plans of buildings, results of researches, and statistics from all countries. This bureau is to be used for international exchange of experience and information;

(3) To plan, convene, and organize international hospital congresses and international post-graduate courses.

The Association was invited to accept membership of the United Kingdom Branch of this body, and the Council decided to accept the invitation. Dr. Peter Macdonald has been appointed as the Association's representative.

Provident Schemes and Payments to General Practitioners for Treatment in Institutions

127. The Council submits the following report on this matter, referred back to it by the A.R.M., 1935:

1. In order to remove the danger of confusion it is desirable to recall the history of the model Provident Scheme. It arose primarily from a public demand. It was felt that in one important respect the section of the community immediately above the hospital class was experiencing considerable difficulty in obtaining medical service of a particular and restricted kind, without recourse to charity or the payment of fees which it could not afford. It was from the angle of this particular section of the public and in respect of a kind of service that this section was having peculiar difficulty in obtaining on a proper basis, that the problem was approached.

2. On this basis a scheme was prepared providing for as full a degree of cover as possible in respect of medical services given in a hospital or nursing home. It was concerned primarily with hospital and nursing home treatment and not with those forms of medical service such as examination and treatment in the home of the consultant and domiciliary general practitioner treatment, the securing of which was not presenting the difficulty referred to in para. 1. Although provision is made in the scheme only in respect of conditions requiring attention within the walls of a hospital or a nursing home, it does not follow, nor is it intended to follow, that the treatment shall be given by men engaged exclusively in consultant and specialist practice. The scheme is concerned with a *type of treatment* rather than with a *class of practitioner*.

3. Speaking generally, the conditions for which persons are treated in hospitals and nursing homes are those requiring consultant or specialist treatment. In some schemes the fact that treatment is given within these buildings is regarded as sufficient evidence that it is of this consultant or specialist kind. In other schemes attempts are made to define the range of service given in such a way as to ensure that it is of a consultant and specialist nature. A scheme based on the model gives payment in respect of consultant or specialist services if given in the pay-beds of a hospital or in a nursing home. It matters not whether the person who gives them is a general practitioner or a consultant, or both, provided the service given is of a particular kind and given in a particular place. In short it is "general practitioner treatment" which is not provided for in this scheme: treatment by general practitioners is certainly not excluded.

4. The Representative Body in 1934 welcomed the model scheme as being in conformity with the hospital policy of the Association, but passed the following resolution:

> *Min. 166.*—Resolved: That the Council be asked to consider whether it would be possible to include in such schemes a definite and limited payment to general practitioners for treatment given by them.

It will be noticed that the Council was asked to consider the inclusion "*in such schemes* of a definite and limited payment to general practitioners." This means the consideration of whether payments to general practitioners can be made in schemes providing for consultant and specialist treatment *in hospitals and nursing homes*. Such schemes do already provide for payments to general

practitioners, provided the treatment given is not what is generally understood as "general practitioner treatment" but is treatment of a consultant or specialist kind given in a hospital or nursing home. The Hospitals Committee sought the view of the Advisory Committee on Provident Schemes on the further question of whether within the ambit of a provident scheme on the lines of the model there could be provided payments to general practitioners *in respect of general practitioner treatment*. On this second question the Council reported to the Representative Body:—

(i) that throughout the whole of the consideration of the model Provident Scheme it was borne in mind that schemes on an insurance basis for this—that is, middle-class—section of the community must rest on a sound actuarial foundation;

(ii) that there is little actuarial experience of any kind available, but it appears that provident schemes for specialist service given in institutions rest on a more secure actuarial basis than can any scheme which endeavours to make provision for general practitioner conditions treated in institutions; and that the existing scheme is available for certain conditions which can be defined with fair accuracy; and

(iii) that in any provident scheme on an insurance basis which provides for payment in respect of conditions treated in an institution, and under which payments would be made in respect of those patients suffering from "general practitioner conditions" there would be the greatest difficulty in estimating the incidence of claims in respect of "general practitioner conditions." The admission of a patient suffering from a "general practitioner condition" to an institution—which would entitle him to the benefits of such a scheme—would depend largely on the wishes of the patient and the general practitioner in attendance. Although this is inevitable and perfectly proper, it would make actuarial calculations practically impossible.

5. Thus it will be seen that the Council gave reasons why it would be very difficult at this stage to evolve an actuarially sound scheme providing for that part of general practitioner treatment which is given in hospitals and nursing homes. The Advisory Committee, upon whose report the Council based the opinion it expressed to the Representative Body, suggested that the larger question of whether it was desirable to evolve insurance schemes to cover general practitioner treatment as a whole should be considered first. It reported in the following terms:—

It may be held that the problem of insurance general medical services should be approached from an entirely different angle—and perhaps not one with which this Committee is equipped to deal—from the angle of the general medical service. In short, it may be wise to consider the problem of insurance provision for *all* general practitioner service for this section of the community. Whether such a scheme provides for repayment of a proportion of general medical services costs or for the full cost of those services up to a stated maximum in each year of membership it seems probable that the organizers would have at their disposal a good deal of information regarding the incidence of general practitioner conditions (for example, from National Health Insurance statistics). The one conditioning factor (of transfer from home to institution) that makes the first scheme extremely difficult to the actuary would be absent from such a scheme. Such a service, while hardly an integral part of a provident scheme of the existing kind, might be run along parallel lines, with the usual process reversed and the general practitioner service an additional benefit available on an additional contribution.

On the whole the Committee, impressed by the difficulties of the limited general practitioner service (due, in the main, to the absence of actuarial data), believes that the larger problem of insurance in respect of *all* conditions falling within the sphere of the general practitioner, whether treated in institution or at home, is the one which demands prior consideration. Although the Advisory Committee is not empowered, or indeed equipped, to discuss the larger problem, it reports to the Hospitals Committee that this is the order in which the problems should be considered.

6. At the A.R.M., 1935, it was pointed out that it was technically difficult to do what Minute 166 of the A.R.M., 1934, had suggested—namely, to provide *within such schemes* payment to general practitioners other than that paid to general practitioners for specialist service, for the technical actuarial reason that any scheme which made payments only when the general practitioner's patient was removed to an institution would be dependent upon and would be conditioned by an uncontrollable factor, whether it be the will of the patient or the wish of the doctor. It was not suggested, indeed the contrary was emphasized, that insurance schemes providing payment in respect of general practitioner services generally could not be evolved. In fact a number existed. The Representative Body on this occasion passed the followng resolution:

Min. 183.—Resolved: That the Supplementary Report of Council under "Hospitals," with the exception of para 173 be approved, and that para. 173 relating to provident schemes for middle-class persons be referred back, since payments to general practitioners under similar conditions are now being made.

(Para. 173 of the Supplementary Report referred to is contained in para. 4 above.)

7. Minute 183 of the A.R.M., 1935, appears to advocate that there should be provided payments for general practitioners in respect of cases admitted to institutions (the 1934 resolution) because "payments to general practitioners under similar conditions are now being made." The schemes quoted in the debate in favour of this statement that such arrangements exist are not schemes providing payment for general practitioner treatment given only in institutions, but schemes in which insurance is made for general practitioner treatment wherever it is given, a quite different thing. The mover of the motion quoted the National Deposit Friendly Society, the Scottish Clerks' Association, and the Warehousemen and Clerks' Association. Particulars of the two last schemes are given below:

Scottish Clerks' Association.—Under the rules subscribers are entitled to call in any *duly qualified medical practitioner* and to claim a refund from the society of the cost of treatment and medicine. Treatment can be institutional or domiciliary by a general practitioner or a specialist.

Warehousemen and Clerks' Association.—The rules provide for a refund, under a definite scale, of the cost of medical attendance and medicine for all contributory members, and it is evident from the scale that it is intended for general practitioner treatment wherever given.

Indeed, there are many bodies which make provision of this kind. They can be quoted in an argument that the whole question of insurance schemes for general practitioner services should be considered, but not in an argument that a provident scheme in dealing with institutional services only shall make payments in respect of that part of general practitioner treatment which is given inside an institution. It seems that the Council was right in stating that, within the type of provident scheme provided for in the model, payments for general practitioner conditions *treated in institutions*—and those only—are not at the moment a sound proposition. The larger question of insurance provision for general practitioner attendance on middle-class persons may, in the view of the Representative Body, need immediate consideration. Such provision is not impossible or even difficult from the actuarial point of view, for it is only the limited and conditioned service which presents the actuarial difficulties.

PROVIDENT SCHEMES FOR MIDDLE-CLASS PERSONS: PERMANENT CENTRAL CO-ORDINATING BODY

128. In view of the active interest taken in the provident scheme movement and the increase in number of new and proposed schemes, a conference of representatives of existing provident associations and other interested bodies was held on March 3rd, 1936, to consider the establishment of a permanent central body to co-ordinate the activities of these schemes. The conference was of opinion that the provident associations are meeting a real need of a section of the community not catered for in the general wards of hospitals. It was decided that a permanent central co-ordinating body should be established in place of the existing *ad hoc* Advisory Committee, and a small committee was appointed from among those present to prepare for consideration at a further conference a draft scheme for the constitution of such co-ordinating body. In the meantime the committee appointed has been authorized to take such steps as it thinks desirable to encourage and assist the development of area associations.

COMMISSION OF BRITISH HOSPITALS ASSOCIATION ON FUTURE OF VOLUNTARY HOSPITALS

129. The British Hospitals Association has recently set up a special Commission, under the chairmanship of Lord Sankey, " to take into consideration the present position of the voluntary hospitals of the country ; to inquire whether, in view of recent legislative and social developments, it is desirable that any steps should be taken to promote their interests, develop their policy, and safeguard their future, and to frame such recommendations as may be thought expedient and acceptable." Sir Henry Brackenbury is a member of the Commission.

The Association having been invited to submit its views, a statement of evidence has been prepared and forwarded to the Commission. This statement was supported by oral evidence given by the chairman of the Hospitals Committee (Dr. P. Macdonald), Mr. N. Bishop Harman, and the Deputy Medical Secretary.

PAYMENT OF MEDICAL STAFFS OF HOSPITALS

130. The Council has considered the following Minute 152 of the A.R.M., 1935, referred to it for consideration:

> *Min. 152.* Proposed by Isle of Wight: That the Representative Body is of opinion that when members of the honorary staff of a voluntary hospital receive payment for services rendered to a public authority, or receive moneys in the form of a staff fund in connexion with their work under a contributory scheme, their status as members of the honorary staff of the hospital should not be affected ; and that the Council be instructed to consider what, if any, amendments to the Hospital Policy of the Association are necessary in order to give effect to the foregoing.

This resolution raises the question of the use of the word " honorary " in describing medical officers who are receiving remuneration in respect of patients treated at the hospitals on the staff of which they serve. Although the visiting staff may receive some remuneration in respect of part of the services rendered to patients at hospital, and in some instances (for example, work done for local authorities) full payment, in relation to the majority of patients for whom payment is received by the hospital the bulk of the professional work is still honorary. There would therefore seem to be nothing in this arrangement which would disentitle the visiting staff to the description " honorary." In the teaching and larger general hospitals, however, the term " honorary " is falling into desuetude, a common description, to take the surgeon as an example, being " surgeon " or " assistant surgeon," or, if no longer on the active staff, " consulting surgeon " ; this practice could be more widely adopted without real loss of status. In the Hospital Policy the adjective " visiting " is applied to this type of medical post. It appears to the Council that the use of the word " honorary " is not of great significance or essential.

The question of the representation of the medical staff on the board of management of the hospital is dealt with in para. 13 of the Hospital Policy:

> " It is essential that visiting staffs of hospitals should have the right of access directly to the governing body of the particular hospital through their accredited representatives."

While the present trend of hospital development is to diminish the amount of strictly honorary work done by the visiting staff, there is nothing in the existing position or in any developments that are likely to take place in the near future which would seem to justify a board of management in refusing representation to the staff, whether the word " honorary " is used or not.

In view of these facts the Council is of opinion that no amendment of the Hospital Policy is necessary to meet the position referred to in Minute 152 of the A.R.M., 1935.

VOLUNTARY HOSPITALS (PAYING PATIENTS) BILL

131. The progress of this Bill has been carefully watched, and necessary action has been taken to secure amendments to certain clauses which appeared to conflict with the policy of the Association regarding the fees chargeable by physicians or surgeons for treatment given by them to patients admitted to pay-beds of hospitals. The Bill in its amended form has now been agreed to by the House of Lords, and is at present before the House of Commons. As it now stands the points raised by the Association are fully met.

OUT-PATIENT POLICY

132. The Association's Report on the Problem of the Out-patient as amended by the Representative Body, 1935, has been reissued to the medical committees of voluntary hospitals and to medical officers of county and county borough councils, with an indication that further copies are available on application to the Medical Secretary. The report has also been republished in the *British Medical Journal* (see *Supplement* of March 28th, 1936).

CONTRIBUTORY SCHEMES

133. In connexion with the following Minute 153 of the A.R.M., 1935:

> *Min. 153.*—Resolved: That in view of the fact that there are now in operation many contributory schemes whose benefits include only the cost of maintenance and nursing, it be referred to the Council to consider what amendments or additions, if any, to the Hospital Policy as relating to remuneration of visiting staffs of the larger voluntary hospitals have now become desirable,

an inquiry has been made of the 335 contributory schemes and organized workmen's collections in England, Scotland, and Wales, and as a result information has been obtained in respect of approximately 80 per cent. of the schemes. The great majority of contributory schemes provide for their members full cover for maintenance, nursing, and medical treatment. Most of the schemes in which benefit is limited to maintenance and nursing operate in areas where the hospitals have unrestricted staffs, and it is known that in the great majority of these cases the medical staff reserve the right to charge the subscriber for medical treatment whilst in hospital. The position in regard to contributory schemes has therefore not changed materially since this part of the Association's policy was adopted, and in view of this fact the Council does not propose amendment of the Hospital Policy.

NAVAL AND MILITARY

MEDICAL BRANCH OF THE ROYAL AIR FORCE

Position of Director of Medical Services

134. The Council drew the attention of the Air Ministry to the fact that it appeared to be customary for the Ministry to promote to the rank of Air Vice-Marshal the officer holding the appointment of Director of Medical Services, R.A.F., some months after his appointment to the Directorate, and that pending promotion to the full rank to which he was entitled this officer occupied a position which was relatively inferior to that of the heads of the medical branches of the other two Services who held the respective ranks of Surgeon Vice-Admiral

and Lieutenant-General as from the date of appointment to their respective Directorates. The Council therefore suggested that the officer appointed as Director of Medical Services, R.A.F., should always be given the rank of Air Vice-Marshal as from the date of his appointment.

The Council regrets that the Department did not accede to this request. The attitude of the Department is that the granting of Air Vice-Marshal rank to coincide automatically with the appointment of Director of Medical Services would not be consonant with the system of promotion in the Air Force. Under this system promotion is not necessarily determined by appointment to a particular post: regard is also given to the reaching of a point in the officer's career at which the higher rank would be appropriate. The Air Council's view is that it would not be practicable to make an exception to this system in the case of the post of Director of Medical Services, Royal Air Force.

The Council is continuing to press its point upon the Department.

Increased Establishment

135. The Council is considering the application of the Warren Fisher Committee recommendations in regard to promotion and up-grading in view of the increased establishment of the medical branch of the Royal Air Force.

Retired Pay of Air Commodores

136. The Council's attention has been directed to the fact that it is possible under the new regulations governing the retired pay for officers in the Royal Air Force for an Air Commodore in the medical branch who enters the service at the age of 28 and who is retired at the age of 57 to receive on retirement retired pay at a rate lower than that which is applicable to a Group Captain in the medical branch with precisely the same period of service. It is a fact also that if a medical officer enters the service at 25 years of age and reaches the rank of Air Commodore he will be entitled on retirement at 57 to a pension of £828, which is only £13 10s. 0d. more than that given to an officer of the next lower rank with precisely the same period of service.

The Council has suggested to the Air Ministry that steps should be taken to remove this anomaly. The Council has also pressed that the increases should be authorized in the pension rates for the two additional years of service now served by Air Commodore and Group Captain in the medical branch.

RATES OF PAY OF RETIRED OFFICERS RE-EMPLOYED IN THE DEFENCE FORCES

137. It is the practice where a retired officer is voluntarily re-employed in the defence forces to pay the officer concerned at a rate lower than that to which he would be entitled had he not been in receipt of retired pay. The Council regards this practice as an undesirable one and recommends:

Recommendation: That the retired pay of medical officers of the defence forces should be regarded as deferred pay and should not be taken into consideration in determining the pay of these medical officers on voluntary re-employment by the defence departments.

REPRESENTATION OF MEDICAL OFFICERS OF HOME DEFENCE FORCES ON NAVAL AND MILITARY COMMITTEE

138. The Council has considered the following Minute 132 of the A.R.M., 1935:

Min. 132.—Resolved: That the following motion be referred to the Council for consideration:

"That the Representative Body is of the opinion that medical officers in the home defence forces (namely, the Royal Naval Volunteer Reserve, the Territorial Army, and the Auxiliary Air Force) should have adequate representation on the Naval and Military Committee; and requests the Council to recommend that representatives from such forces should be co-opted on that Committee;"

and arrangements have been made to ensure that when questions affecting medical officers of the home defence forces are under consideration by the Naval and Military Committee a medical officer or officers of these forces will be invited to attend the meeting of the Committee.

CONSULTANTS AND SPECIALISTS

COUNCIL GENERAL HOSPITALS

139. The Council has had under consideration the general question of the position of the consultant and specialist in connexion with the staffing of council hospitals.

A questionary was issued to medical officers of health of county boroughs in England and Wales with a view to collecting information as to the terms and conditions of employment of the medical staffs of council hospitals, and other relevant data. Information was obtained as to some thirty provincial county borough council hospitals administered under the Public Health Acts. In addition, there existed at that time some thirty-one general hospitals controlled by the London County Council, and three or four similar hospitals controlled by county councils. The number of hospitals administered under the Public Health Acts (in preference to the Poor Law) increases each year.

The information obtained indicates that in the majority of the larger towns one or more of the hospitals formerly administered under the Poor Law is now administered under the Public Health Acts.

(a) Method of Admission

The relieving officer, formerly an essential part of the machinery of admission, is fast disappearing from his place between the patient and the hospital. Almost invariably patients are admitted via the medical superintendent, an arrangement approximating to, if not easier than, the method of admission to voluntary hospitals.

The Council is of opinion that the tendency to admit patients via the medical superintendent is one which should receive the approval of the Association.

(b) Type of Case, Clinical and Social

Although some of the appropriated hospitals retain a number of chronic cases the amount of acute general medical and surgical work is obviously increasing. Where there is more than one hospital in a town segregration is going on, with the result that a large number of hospitals undertaking mainly acute work are being set up. Almost invariably an increase in the number of acute cases is reported. With one or two exceptions the social status is improving, and some hospitals proudly report that the more well-to-do classes are seeking admission.

The information collected indicates that both the voluntary and the council hospitals are dealing with the same section of the community, and the Council is of opinion that this will encourage a greater degree of uniformity in the organization and staffing of the two types of hospital.

(c) The Professional Standing of the Permanent Staffs

With the exception of London and one large provincial town the professional standing of medical superintendents and permanent medical officers is roughly the same as before appropriation. Indeed, too little time has elapsed for a change of personnel to be effected by the normal process of retirement and replacement. It is not possible to say from the returns whether there exists any tendency to fill these offices as vacancies occur by men of higher academic attainments, although this is very probable. Almost invariably part-time consultants are being attached to these hospitals in increasing numbers, and the general tendency seems to be to use them for the main specialist work of the hospitals.

(d) Daily Cost of Maintenance

The daily cost, including the cost of payment for medical services rendered by the resident and visiting

staffs, varies from 3s. 11d. to 8s. 11d., the average being in the region of 6s., except in one area, where the figures vary between 11s. and 12s. and in another (which has a new hospital) the figure is 11s. 7d. The importance of this figure lies in the fact that this represents the most that the ordinary patient is called upon to pay for all services ; indeed, the average patient will pay considerably less.

(e) Arrangements with Contributory Schemes

Considerably more than a half of the local authorities have made arrangements with the local contributory schemes to accept their payments in lieu of the direct assessment of patients.

This the Council considers is all to the good, as it will facilitate a closer co-operation between the voluntary and municipal hospitals. The need for the separation of contributory schemes from particular hospitals is apparent.

(f) Private Patients

A striking feature of the returns is that in ten of the thirty appropriated hospitals examined arrangements of some kind for the admission of private patients exist. In only one of these ten hospitals does the local authority definitely recognize the payment of the practitioner: in this case the doctor reaches his own arrangement with the patient. In three of the hospitals " if a patient makes any arrangement privately with a consultant the Corporation does not interfere."

The Council is of opinion that if there are to be private wards in council hospitals the medical fee (irrespective of what charge is made to the patient for maintenance costs) should be a matter for private arrangement between the patient and his private medical attendant—whether or not the latter is a member of the staff of the hospital—unless special arrangements are reached with the profession.

In order to secure that medical practitioners are not exploited in the private wards of council hospitals:

(*a*) terms and conditions of service of medical practitioners appointed to council hospital staffs should confer responsibility in respect only of persons not treated in private wards ;

(*b*) the rate of maintenance of persons treated in private wards should not include amounts in respect of the services of visiting medical practitioners, whether appointed to the hospital staff or not ;

(*c*) the fees for the services of such visiting practitioners, whether appointed to the hospital staff or not, should be a matter of arrangement between the patient and the practitioner.

(g) Ambulance Service

Invariably an ambulance service exists for the benefit of municipal patients, and as a general rule the charge for it comes within the ordinary maintenance charge. Rarely is the same ambulance service available for voluntary hospitals, and where it is there is a definite charge for its use. On the assumption that the voluntary hospital charges for the use of its ambulance the effect of this arrangement may be to suggest to the patient that if he goes to a voluntary hospital there is a charge and—although technically it is not true—if he goes to the municipal hospital there is no charge.

(h) Out-Patient Departments

In nine cases out of thirty the reply " Yes " is given to the question " Is there an out-patient department? " In some of these it is qualified by the statement that it is limited to a certain type of case and to old in-patients. In the case of nine hospitals giving the answer " No " it is stated that some limited continuation treatment is given.

The Council is of opinion that in those instances where it is considered necessary in the public interest to establish an out-patient department, Recommendation 9 of the Association's Out-patient Policy be applied—namely,

" Only such treatment should be given at the department as cannot in the best interests of the patient be obtained elsewhere under the usual arrangements as between private practitioner and private patient, or under contract arrangements."

Where continuation treatment is given to a council hospital patient outside the institution, paras. 52 and 53 of the Hospital Policy of the Association should apply.

(i) Contemplated Extensions

Only five of the thirty hospitals state that no extension, enlargement, or reorganization is under contemplation. In general, local authorities contemplate very considerable rebuilding and extension of premises and increase of medical and nursing staff.

The Council recommends:

Recommendation : That the above report on Council General Hospitals be approved.

Regional Meetings

140. Under the scheme of constitution, meetings of members of the Group in each of the thirteen regions have for the first time been held this session. On the whole the meetings were satisfactory and members of the Group attending showed an appreciation of the action of the Association in creating the Group. There has been issued to every member of the Group a statement of the year's work of the Committee.

OVERSEA BRANCHES

Conference of Oversea Members

141. A Conference of Oversea Members will be held during the Annual Meeting, 1936, at Oxford, and all oversea members who are present at the Meeting will be invited to attend. The Council will welcome any suggestions from Oversea Branches or Divisions for subjects for consideration.

Model Agreement between Companies and Medical Officers Overseas

142. The Council reported last year that a Model Form of Agreement between commercial companies and medical officers overseas was being prepared. The Model Agreement and an Explanatory Memorandum are now available, and copies may be obtained on application to the Medical Secretary. It is hoped that the Model Agreement will be of value to those medical practitioners who propose to accept appointments overseas as medical officers to commercial companies. If such medical officers ensure that the agreements which they sign include the provisions mentioned in the model, it should be possible to avoid the difficulties which have frequently resulted in the past from the signing of agreements which are inadequate and liable to misinterpretation.

Leeward Islands Medical Service

143. As no reply has been received by the Leeward Islands Branch to the Petition referred to in the Council's Supplementary Report last year, the Colonial Office has been approached direct by the Council. The position of the medical officers is being rendered increasingly difficult by reason of the diminution of the private practice which is expected to supplement their official salaries. The Council hopes to be able to make a further report on the progress of negotiations in its Supplementary Report.

African Medical Officers

144. The Council referred last year in its Supplementary Report to the Petition submitted to the Colonial Office

by the African Medical Officers in West Africa asking for the removal of the word " African " from their title and for improvements in their status, salaries, pensions, and facilities for study leave. The Colonial Office has agreed to omit the word " African " from the title of these officers, but has rejected their other proposals.

European Medical Officers in West Africa

145. The Colonial Office proposes to introduce a revised salaries scale for European medical officers in West Africa. As the new scale involves important alterations, including a reduced pension basis rate, the Council is seeking an assurance from the Colonial Office that the new conditions shall not be applied to existing medical officers without their consent. The medical officers in Nigeria have presented a memorial to the Secretary of State for the Colonies asking for the reconsideration of the new scale and suggesting certain amendments.

Temporary Allowances for Officers in the Malayan Medical Service

146. The Malaya Branch has asked the assistance of the Council in obtaining the restoration of temporary allowances which were withdrawn in 1932. These allowances were awarded on the understanding that they were strictly temporary and that they might be varied or discontinued at any time. They have been subjected to gradual reduction ; in 1929 an allowance of 10 per cent. was paid to unmarried officers and 20 per cent. to married officers ; in 1931 the rates were 5 per cent. and 10 per cent. respectively. As the cost of living in Malaya appears to be rising and as certain private firms and municipal bodies have already increased salaries or restored temporary deductions, a letter was addressed to the Colonial Office supporting the Branch's claim. The Colonial Office has replied that the question is one which affects the whole Malayan Civil Service, and that it is open to the medical officers to submit their case through the usual official channels. It has accordingly been suggested to the Branch that it should prepare a Memorial.

Colonial Medical Councils

147. A member of an Oversea Branch who had been censured by the local Medical Council suggested that medical practitioners in the Colonies were at a disadvantage in relation to disciplinary control because the powers and procedure of local medical councils varied between colony and colony, and he proposed the establishment for the smaller colonies of a uniform procedure which would give to the General Medical Council the general direction of colonial medical councils. The Oversea Branches in whose areas colonial medical councils exist have been asked for their opinions on the suggestion. Some replies have already been received, but the Council is postponing further action until the remainder are obtained.

Visit of Medical Secretary to India

148. After a careful consideration of the position in India and after receiving invitations from Indian Branches, the Council has decided to appoint the Medical Secretary as its representative to make a tour of the Indian Branches and to suggest methods for the possible improvement of the organization of the medical profession in India. He will travel to India in the late autumn.

Licensing Ordinance, Kenya

149. The Council referred in its Supplementary Report last year to the Licensing Ordinance in Kenya, under which medical practitioners (and members of other professions) were to be required to pay an annual licence fee of £15. Following protests by the Branch locally and by the Council this Ordinance has now been withdrawn.

SCOTLAND

Highlands and Islands Medical Service

150. The Council is glad to report that after consideration of the arrangements to be adopted subsequent to the expiry of the quinquennial agreement at the end of 1935 the Department of Health for Scotland is prepared to recommend that no reduction be made in the moneys presently provided for the Highlands and Islands Medical Fund.

Departmental Committee on Scottish Health Services

151. The report of the Departmental Committee is expected to be published during the month of May. The report will contain recommendations likely to have far-reaching effects on the medical services of the country, and will require careful consideration by the Association.

Central Midwives Board for Scotland

152. The Scottish Committee has appointed Dr. R. C. Buist, Dundee, and Dr. James Cook, Glasgow, as its representatives on the Central Midwives Board for the ensuing quinquennium. Dr. R. C. Buist has been reappointed chairman of the Board.

Public Assistance Medical Service

153. The Corporation of Glasgow has established a whole-time service for medical attendance on persons in receipt of public assistance in the city ; Clydebank Town Council has, on the other hand, introduced the system of " open choice."

Presentation to Scottish House

154. The Council has pleasure in reporting the presentation by Dr. C. E. Douglas, as a souvenir of the World Tour of the Association in 1935, of a plaque representing Imhotep—" the first physician with a distinct personality to stand out in the mists of antiquity."

PARLIAMENTARY ELECTIONS

November, 1935, General Election

155. Two members, candidates at the above election, applied for the Association's support of their candidature and for financial assistance, one being a Labour candidate and the other a Liberal candidate. Both candidates were able to satisfy the conditions for approval laid down by the Council—namely, that they should by past work and experience have proved their knowledge of and loyalty to the interests of the profession, that they should be willing to inform and advise the Trustees of the Medical Representation in Parliament Fund through their representatives as to any procedure arising in Parliament likely to affect the medical profession, and that they should be in general agreement with the views of the British Medical Association. The candidature of the Labour candidate was approved, and he was granted a sum of £250 from the Fund. While the Liberal candidate satisfied the conditions, it was not found possible to approve his candidature, because he appeared to have very little chance of success. Neither of these two candidates was successful in securing election.

Two members of the previous Parliament asked for the Association's approval of their candidature, although not asking for financial assistance. The conditions for approval by the Association were fulfilled and approval was given to both candidatures. One of these two members was re-elected to Parliament.

In the case of the three members whose candidatures were approved, members of the Association in their constituencies were, with the approval of the Division concerned, asked to give them such support as they felt they could give.

MEDICAL ASPECTS OF ABORTION

156. The Council submits for the information of members of the Association the report of the Committee *re* Medical Aspects of Abortion (see Appendix VII). The Council regards the report as a contribution of great practical value, and it hopes that the views of this Committee will receive careful attention.

The Representative Meeting will be asked to consider the publication of the Report of the Committee in pamphlet form.

MINERS' NYSTAGMUS

157. At the last Annual Representative Meeting the view was expressed that the existing procedure under the Workmen's Compensation Act, applicable to cases of miners' nystagmus, was a matter of serious concern, and the Council was requested to initiate such action as might contribute towards the adoption of improved methods of procedure. Accordingly, on July 23rd, 1935, the Council appointed a special committee with the following reference:

> "To consider and report upon the possibility of securing improved methods of procedure in the diagnosis and certification of miners' nystagmus."

Subsequently, it was learned that the Secretary of State for Home Affairs had appointed a Departmental Committee to inquire into the operation of the Workmen's Compensation Act, with special reference to the procedure for dealing with those claiming and found to be suffering from miners' nystagmus. The Association was invited to give evidence before the Departmental Committee, and the report of the special committee appointed by the Council, which is now presented to the Representative Body (see Appendix VIII) has been submitted to the Departmental Committee as the basis of the evidence given by the Association's witnesses, Sir John Parsons, C.B.E., LL.D., F.R.C.S., F.R.S. (London), Dr. T. L. Llewellyn (Nottingham), and the Medical Secretary.

PHYSICAL EDUCATION

158. The Council reported last year that, in consequence of a statement made at the Council Dinner on November 6th, 1934, by the Right Honourable Sir Hilton Young, the then Minister of Health, it had appointed a special committee "To consider and report upon the necessity for the cultivation of the physical development of the civilian population and the methods to be pursued for this object." The personnel of the Committee was representative not only of medical opinion but also of the professional and technical aspects of the subject, and information has been collected from a large number of interested bodies and individuals. The Committee issued a progress report in July, 1935, and its final report was published in the *British Medical Journal Supplement* on April 18th, 1936. The Council wishes to draw the attention of members to this comprehensive report, in which the conviction is expressed that there should in future be a far closer and more intimate relation than has existed in the past between physical education and the science and art of medicine.

E. KAYE LE FLEMING,
Chairman of Council.

APPENDIX I

RETURN OF ATTENDANCES

at Council Meetings, from the termination of Annual Representative Meeting, 1935, up to and including April 8th, 1936

COUNCIL

Chairman: E. KAYE LE FLEMING

NAME	ATTENDANCES	
	Actual	Possible
Chairman of Council: E. Kaye Le Fleming, Wimborne	4	4
President: Sir James Barrett, Melbourne	0	4
Chairman of Representative Body: H. S. Souttar, London	4	4
Treasurer: N. Bishop Harman, London	4	4
President-Elect: Sir Farquhar Buzzard, Oxford	4	4
Past-President: S. Watson Smith, Bournemouth	2	4
Deputy Chairman of Representative Body: H. G. Dain, Birmingham	4	4
Armstrong, J., Ballymena	3	4
Berry, R. J. A., Bristol	4	4
Bigger, J. W., Dublin	3	4
Bone, J. W., Luton	3	4
Brackenbury, Sir Henry, London	4	4
Burgess, A. H., Cheadle	4	4
Comrie, J. D., Edinburgh	4	4
Conoley, O. F., Leighton Buzzard	2	4
Dunhill, Sir Thomas, London	1	4
Eccles, W. McAdam, London	4	4
English, Sir Crisp, London	3	4
Flemming, C. E. S., Bradford-on-Avon	3	4
Fothergill, E. R., Hove	4	4
Fraser, T., Aberdeen	2	4
Gilks, J. L., Petersfield	4	4
Giuseppi, P. L., Felixstowe	0	4
Glover, L. G., London	4	4
Goodbody, F. W., London	4	4
Gordon, R. G., Bath	4	4
Harold, C. H. H., London	4	4
Hawthorne, C. O., London	4	4
Henderson, J., Glasgow	3	4
Hudson, J., Newcastle-upon-Tyne	4	4
Hunter, J., Edinburgh	3	4
Jonas, H. C., Barnstaple	4	4
Langdon-Down, R., Teddington	4	4
Lilley, E. Lewis, Leicester	4	4
Loudon, J. Livingston, Hamilton	3	4
Loughridge, J. C., Belfast	4	4
Macdonald, P., York	4	4
Maclean, Sir Ewen, Cardiff	3	4
Manson, J. S., Warrington	4	4
Matthews, J. C., Downton	4	4
Miller, J. B., Bishopbriggs	4	4
Milligan, H. J., Reading	3	4
Needham, Sir Richard, London	2	4
Newell, R. L., Cheadle	3	4
Parry, L. A., Hove	4	4
Paterson, W., London	4	4
Peacocke, R. C., Blackrock	3	4
Picken, R. M. F., Cardiff	3	4
Pooler, H. W., Stonebroom	3	4
Proctor, A. H., London	4	4
Prytherch, J. R., Llangefni	4	4
Robinson, H., London	4	4
Snell, E. H., Coventry	4	4
Spurgin, P. B., London	4	4
Thomas, A. R., Bognor Regis	4	4
Thomas, W. E., Ystrad Rhondda	4	4
Trotter, G. Clark, London	4	4
Turner, H. M. Stanley, Ashtead	2	4
Wand, S., Birmingham	4	4
Waterfield, N. E., Great Bookham	4	4
Watkins-Pitchford, W., Bridgnorth	3	4
West-Watson, W. N., Bradford	4	4
Willoughby, W. G., Eastbourne	3	4
Wood, F. T. H., Liverpool	3	4

APPENDIX II

(FINANCIAL STATEMENT)

(*See Supplement, May 2nd, 1936*)

APPENDIX III

PROPOSED AMENDMENTS TO ARTICLES AND BY-LAWS

(I)—ARTICLES

Page 12, *Art.* 10 (*a*) ("*Expulsion*"), *lines* 6 *and* 7: *Substitute:*

" hereinafter prescribed " for " prescribed by the By-laws."

Page 18, *Art.* 17 ("*Membership*"), *line* 2. *Substitute:*

" Register of Members " for " books."

Page 20, *Art.* 26 ("*Notice of Meetings*"), *line* 7. *Substitute:*

" hereinafter prescribed " for " prescribed by the By-laws."

Page 20, *Art.* 27 ("*Business of Annual General Meeting*"), *line* 4. *Insert:*

after " transacted at such meeting " the following:

" including the appointment of an Auditor or Auditors (who shall be a professional accountant or professional accountants) and the fixing of his or their remuneration;"

Page 21, *Art.* 30 ("*Special Business of General Meetings*"), *lines* 5–10. *Delete sentence:*

" No business shall be discussed or transacted in any General Meeting as special business, except such business as by Statute must be dealt with by Special Resolution, and such business as the Regulations or By-laws of the Association may at any time expressly require to be dealt with in General Meetings."

Page 21, *Art.* 31 ("*Procedure at General Meetings*"). *Delete the Article and heading; and substitute the following new Articles to be numbered* 31, 32, 33, 34 and 35:

Chairman

" 31.—The President of the Association, if present, shall preside as Chairman at the opening of every General Meeting. In the absence of the President, the Chairman of Council shall preside, and in his absence a Chairman shall be appointed by the Meeting."

Quorum

" 32.—Except as hereinafter provided no business shall be transacted in any General Meeting unless there be present a quorum of not less than 100 Members. If within one hour from the time appointed for the Meeting such quorum be not present, the Meeting, if convened upon the requisition of Members, shall be dissolved. In any other case it shall stand adjourned to the same day in the following week, at the same time and place, and if at such adjourned Meeting a quorum be not present, those present shall be deemed to be a quorum."

Adjournment of Meetings

" 33.—The Chairman of any General Meeting may, with the consent of the Meeting, adjourn any business from time to time and from place to place, but no business shall be transacted at any adjourned Meeting other than the business left unfinished at the Meeting from which the adjournment took place."

Voting at General Meetings

" 34.—At a General Meeting, unless a poll is demanded in writing by at least five Members, a declaration by the Chairman that a Resolution has been carried, or carried by a particular majority, or lost or not carried by a particular majority, and an entry to that effect in the book of proceedings of the Association shall be sufficient evidence of the fact without proof of the number or proportion of the votes recorded in favour of or against any such Resolution. If a poll be demanded by five Members or more, the same shall be taken in such manner and either at once or after an interval or adjournment, as the Chairman directs, and the result of such poll shall be deemed to be the Resolution of the Association in General Meeting. On a show of hands every Member present in person shall have one vote, and upon a poll every Member present in person shall have one vote. Votes must be given personally. In case of any equality of votes at any General Meeting the Chairman shall have a second or casting vote."

" 35.—Any Resolution passed at a General Meeting shall (save as hereinafter provided) be subject to the provisions as to Referendum hereinafter contained."

Pages 21–26, *Arts.* 32–37 *to be renumbered* 36–41.

Page 26. *Insert following new Article* 42 ("*Seal*") *immediately before existing Article* 38 ("*Affiliation*"):

Seal

" 42.—The Council shall provide for the safe custody of the seal of the Association, and the seal shall not be used except in pursuance of a resolution of the Council and in the presence of at least one Member of the Council and of a Secretary of the Association, who shall sign every instrument to which the seal is affixed."

Pages 26–28, *Arts.* 38–46 *to be renumbered* 43–51.

Page 26, *Art.* 38 ("*Affiliation*"), *last line. Substitute:*

" Article 39 " for " Article 35."

Page 28. *Insert after existing Article* 46 ("*By-laws*"), *following new Articles to be numbered* 52, 53 *and* 54:

Notices

" 52.—(1) A Notice may be served by the Association upon any Member, either personally or by sending it through the post in a prepaid letter, addressed to such Member at his address appearing in the Register of Members, or by publication of such notice in the Journal, and sending a copy of the Journal containing such notice to such Member, prepaid and addressed as above-mentioned.

(2) A notice may be served on any Division or Branch by serving the same as aforesaid on the Secretary of such Division or Branch, and if there be none, then on any two Members of such Division or Branch.

(3) Any notice, if served by post, shall be deemed to have been served on the day following that on which the letter, or a copy of the Journal containing the same, is posted, and in proving such service it shall be sufficient to prove that the letter, or a copy of the Journal containing the notice, was properly addressed and put into the Post Office."

Validity of Proceedings

" 53.—The proceedings of the Representative Body or of the Council, or of the Council of any Branch (other than a Corporate Branch) or of any Committee or other Body acting under the Regulations or the By-laws, shall not be invalidated by any accidental omission to

give any notice thereby required or by any vacancy among their Members, or by any defect in the election or qualification of any of their Members."

" 54.—Where by the Regulations or the By-laws any act or thing is required to be done by the Association, the same may be done by such officer of the Association as the Council may appoint for the purpose."

(*II*) *BY-LAWS*

Page 29, *By-law* 1 (3) (" *Interpretation* "). *Insert at end :*

" or who has been for a period of not less than 10 years so employed and is a whole time teacher of public health at a University or Medical School in Great Britain or Northern Ireland and whose name is in either case distinguished in the Register of Members of the Association as a Public Health Service Member."

Page 30, *By-law* 5 (" *Election by Branches* "). *Insert following new sub-paragraph* (3) *:*

" (3) Forthwith upon a Member being elected by a Branch, the Branch Secretary shall give notice in writing thereof to the Association at the Head Office."

By-law 12 (" *Extraordinary Members—'Associate,' 'Complimentary* ' "), *line* 3 *on Page* 33. After " ordinary membership of the Association " *insert :*

" An Extraordinary Member shall not, as such, be entitled to any vote."

Page 33, *By-law* 13 (" *Annual List of Members* "). *Delete* present sub-paragraph (2), and *substitute* following :

" (2) For all the purposes of the Regulations and the By-laws the persons for the time being named in the Register of Members of the Association whose respective addresses are situate at places within the area of any Division, Corporate Branch or Corporate Group and no others shall be deemed to be the Ordinary Members of that Division, Corporate Branch, or Corporate Group and the persons for the time being Ordinary Members of the Divisions comprised in a Branch and no others shall be deemed to be the Ordinary Members of that Branch and the persons whose names are for the time being distinguished in the Register of Members of the Association as Public Health Service Members and no others, shall be deemed to be the Public Health Service Members."

Page 45, *By-law* 31 (1) (" *Grants to Branches : Ordinary* "), *lines* 5 *and* 6. *Delete :*

" Member of that Branch whose name appears in the Annual List for the time being in force."

and substitute :

" person whose name appears as a Member of that Branch in the Register of Members as at 30th April then last past."

Page 47, *By-law* 36 (2) (" *V. Special Groups of Members* "), *last line. Substitute :*

" 39th " for " 35th."

Pages 47–49, *By-laws* 37–41 *transferred to Articles.*

Pages 49–68, *By-laws* 42–89 *to be renumbered* 37–84.

Page 50, *By-law* 44 (2) (" *Number of Representatives* "), *line* 3. *Delete :*

" Annual List in force at the time of the election "

and substitute :

" Register of Members of the Association."

Page 52, *By-law* 47 (2) (" *Deputy-Representative* "), *line* 2. *Substitute :*

" 40 " for " 45."

Page 52, *By-law* 47 (4) (*Ditto*), *line* 6. *Substitute :*

" 52 " for " 57."

Page 53, *By-law* 48 (3) (" *Representatives of Public Health Service Members* "), *line* 6. *Substitute :*

" 54 " for " 59."

Page 56, *By-law* 53 (3) (" *Voting* "), *lines* 6 *and* 7. *Delete :*

" according to the Annual List then in force "

and *substitute :*

" according to the Register of Members as at 30th June then last past;"

Page 60, *By-law* 60 (4) (" *Mode of Election by Groups not in Great Britain or Northern Ireland* "), *line* 6. *Substitute :*

" shall " for " may."

Page 61, *By-law* 62 (" *Mode of Nomination and Election by Public Health Service Members* "), *line* 6. *Substitute :*

" 54 " for " 59."

Page 65, *By-law* 73 (" *Chairman and Deputy-Chairman of Representative Body* "), *last line. Substitute :*

" 42 " for " 47."

Page 67, *By-law* 82 (" *X. Committees and Standing Committees* "). (*a*) By-law 82 to be re-numbered 82 (1) ; and amended as follows :

(i) line 1 : before " Scottish " insert " Insurance Acts,"

(ii) line 4 : before " Each " insert " Except in the case of the Insurance Acts Committee,"

(*b*) *Insert* following new sub-paragraph (2) :

" (2) The Insurance Acts Committee shall have power to appoint any Member of the Committee as Chairman, provided that, if the Member appointed as Chairman is not a Member of Council, the Committee shall appoint from among its own number a Member of Council as Deputy Chairman."

Page 68 *By-law* 89 (" *XI. Expenses* "), *line* 2. *Substitute :*

" 48th " for " 43rd."

Pages 68–9, *By-laws* 90–93 *transferred to Articles.*

Page 74, *Schedule to By-laws relating to Public Health Committee*, 5*th Column. Insert :*

" 1 to be appointed by the Hospitals Committee."

Page 75, *Schedule to By-laws relating to Insurance Acts Committee :*

" (a) 5*th Column, line* 8. *Substitute :*

" By-law 38 " for " By-law 43."

(b) 6*th Column*, 37*th*–39*th lines. Delete* words :

" Poor Law Medical Officers' Association of England and Wales,"

and *substitute :*

" Association of Local Government Medical Officers of England and Wales."

Page 76, *Schedule to By-laws relating to Hospitals Committee :*

(a) 5*th Column. Insert :*

" 1 to be appointed by the Public Health Committee ; 1 to be nominated by the Medical Superintendents' Society."

(b) 6*th Column*, 6*th*–16*th lines. Delete* all words after " to co-opt " and *substitute :*

" 3 members if necessary to secure representation of a particular class of experience not otherwise represented on the Committee."

APPENDIX IV

MEMORANDUM OF EVIDENCE SUBMITTED TO THE DEPARTMENTAL COMMITTEE ON THE WORKMEN'S COMPENSATION ACT ON THE MEDICAL QUESTIONS COMING WITHIN THE REFERENCE OF THAT COMMITTEE (OTHER THAN MINERS' NYSTAGMUS)

I.—PRELIMINARY

1. The British Medical Association is a company formed for scientific and other useful purposes and not for profit, and incorporated under the Companies Acts. Its main objects are the promotion of the medical and allied sciences and the maintenance of the honour and interests of the medical profession. It has a membership of 35,500, which includes the great majority of the practising members of the profession in this country.

2. Realizing the importance of the problems which the Departmental Committee has to examine in accordance with its terms of reference, the Council of the Association has set up a Special Committee consisting of members of the profession who have had special experience of the medical problems which arise as the result of the operation of the existing Workmen's Compensation Acts.

3. The Committee regrets that the terms of reference of the Departmental Committee should have been framed so as to preclude consideration of the problems of workmen's compensation as a whole, and in particular a number of pressing questions such as the organization, supervision, and co-ordination of the treatment and rehabilitation of the injured workman.

4. The Committee is convinced that any mere amendment of the Workmen's Compensation Act with a view to removing certain of the more obvious anomalies will not meet the most serious fault of the present system. The time has come to recognize a new principle—that it is necessary not merely to pay compensation to a disabled workman, but to provide adequate facilities for the restoration of his earning capacity. The Association's Committee strongly urges that the Departmental Committee should recommend that steps should at once be taken to consider this important problem.

5. Having thus expressed itself, the Committee proposes to confine its observations to the medical aspect of the questions contained in the Departmental Committee's reference, as it is from this particular point of view that it is specially qualified to speak. It is not proposed to deal here with the question of miners' nystagmus, which will be dealt with in a separate report.

II.—CASES ADMITTED FOR COMPENSATION WHICH ARE NOT THE SUBJECT OF DISPUTE

6. A large proportion of the cases of injury to the workmen which come under the Workmen's Compensation Acts do not involve any question of dispute between the employer and the workman. The employer (and any acting on his behalf) is satisfied that the workman, as a result of injuries sustained in the course of his employment, is entitled to compensation. There is no dispute as to the facts, compensation is paid in accordance with the statutory provisions; in the vast majority of cases the workman returns to his ordinary employment when he has recovered from his injuries. The Committee sees no reason to suggest any change in the present procedure in regard to undisputed claims, although it appears to it that the machinery of the "declaration of liability" is too infrequently utilized and, in many of the cases in which it is used, too tardily set into motion, with a consequent delay which may react adversely on the workman and delay his return to work.

7. It is the practice of some insurance companies acting on behalf of any employer to ask the workman when he first claims compensation to produce a medical certificate of incapacity and to state on such form of request that the fee for the certificate must be paid by the workman. As under the Act there is no obligation on the workman to produce such a certificate but merely to give notice of incapacity to his employer, the Committee considers that due publicity should be given to this fact in order that this practice of asking the workman to supply a certificate at his own expense should be stopped.

III.—THE POSITION OF THE MEDICAL REFEREE

(*a*) *The Present Position*

8. An examination of the position of the medical referee reveals some unsatisfactory features.

The medical referee is appointed by the Secretary of State under Section 38 of the Act. His duty in claims for compensation for injuries is to act in those cases referred to him by the registrar of the court where there is conflict of medical opinion and where there is a joint request by the workman and the employer, or, subject to appeal to the judge, a request by one of the parties. He is required to give a certificate as to the condition of the workman and as to his fitness for employment, specifying, where necessary, the kind of employment for which he (the workman) is fitted, the certificate of the referee being conclusive evidence as to the matter so certified. Where there is reference to the referee by agreement, both parties are bound by the medical referee's report. In cases of industrial disease the workman or the employer, if aggrieved by the action of the certifying surgeon, may appeal to a medical referee, provided appeal is made within ten days.

9. Under para. 5 of the First Schedule to the Act a judge of county courts may in "any case if he thinks fit and shall, if any party in accordance with rules of courts so requires . . . summon a medical referee to sit with him as assessor." It has been laid down in various judgements given in the courts that the duty of the assessor is to advise on medical matters and by his expert knowledge to assist the judge to arrive at a proper conclusion. Having formed his conclusions on the facts, the judge may seek the advice of the assessor as to the scientific inferences to be drawn from those facts. He may be guided by the advice given, but he is not bound to do so, and he may disregard it.

10. Thus it will be seen that a medical referee may act in one of two capacities. He may act as a *medical referee* in cases of injury and, where there is an appeal, from the findings of the certifying factory surgeon in cases of industrial diseases. He may, if called upon to sit with the judge in an advisory capacity, act as a *medical assessor*.

(*b*) *General Comment*

11. The functions of the medical referee are of considerable importance. When the Workmen's Compensation Act, 1925, was passed it was believed that the majority of cases of personal injury by accident arising out of and in the course of the workman's employment which were the subject of dispute between the workman and his employer, would be referred to a medical referee, with a view to obtaining conclusive evidence as to the condition of the workman, and as to his fitness for employment. The working of the Act has shown the fallacy of this belief. Recourse to the medical referee in

disputed claims is, in many parts of the country, the exception rather than the rule. It appears that both workmen and employers prefer to bring the case before the judge and have the medical facts fought out in court, a procedure which frequently necessitates the calling of expert medical evidence on both sides with its consequent expense. It is more difficult for the workman than for the employer to secure the services of expert medical witnesses unless he has behind him the financial support of a trade union.

12. Several reasons for this attitude in not referring cases to medical referees may be brought forward:

(*a*) Medical referees are sometimes appointed with insufficient experience or qualification for the duties they are called upon to undertake. In this connexion it should be appreciated that no special qualifications for the post are laid down, although the Secretary of State invariably appoints practitioners of some years' standing in their profession.

(*b*) Where there are conflicting medical opinions it often occurs that the relative standing of those presenting such opinions on behalf of the interested parties and of the medical referee results in a case being sent to the court instead of being referred to the medical referee. It is significant also that, in cases of agreed reference to the medical referee, one person makes the decision, and that this decision is final.

(*c*) The present unsatisfactory rate of remuneration of medical referees is another factor of importance, as it limits the choice of the Secretary of State in the matter of these appointments. Many practitioners eminently suitable for the posts are not prepared to accept them so long as the remuneration remains inadequate.

13. In cases of scheduled industrial diseases the principal criticism of the system of medical referees arises from the fact that the list of scheduled diseases has been so extended that it is impossible for one medical practitioner to be expert in all the various conditions which may come before him.

14. In the case of medical assessors there is a great variation in the frequency with which judges act on the provision of para. 5 of the First Schedule of the Act. Some judges rarely summon medical referees to sit with them as assessors; others summon them to act in this capacity in a considerable number of cases. This section also gives power to either of the parties to ask that a medical referee should act as a medical assessor, but in actual practice, where the judge is known to attach little importance to the presence of a medical referee acting as an assessor, the parties rarely act on this provision.

15. The Committee is convinced that the existing medical referee machinery has not satisfied the purpose for which it was created. In the interests of all concerned a complete change appears to be essential.

(*c*) *Proposed Changes*

16. The Committee suggests that the office of medical referee should be abolished, and that there should be set up in substitution Boards of Referees composed as undermentioned and having the following duties and powers:

Composition: The Board should be composed of three registered medical practitioners, two of whom should be permanent, the third member to be appointed by the permanent members according to the medical aspects of the case to be considered by the Board. The permanent members of the Board should be a surgeon of consultant status and a general practitioner of standing in his profession, and the third member of the Board should be chosen from a panel of experts drawn up by the Home Office. If in exceptional circumstances the Board is satisfied that it requires further expert assistance, it should be empowered to obtain such assistance.

Duties and Powers: (1) To deal through the registrar with *all* cases relative to compensation for injuries where there is a conflict of medical opinion, and to deal also with such cases as are referred to the Board by a county court judge.

(2) To deal with *all* cases of industrial diseases at present referred to the medical referee under Section 43 (1) (*f*).

(3) To conduct re-examinations in cases of industrial disease in which compensation has been admitted and is being paid but in which an appeal is made either by the workman or by the employer with a view to a further ascertainment of the physical condition of the workman (see para. 22).

The Board should have before it the medical history of the case, including the medical certificates and medical reports from both sides, and such additional medical data as it may desire to obtain.

The Board should state in writing the facts found and the inferences drawn from such facts.

In cases of accident the Board should

(i) *Certify* (*a*) the condition of the workman and his fitness for employment; (*b*) the extent to which the workman's incapacity is due to the accident. The certificate of the Board should be conclusive and final evidence on the medical matters so certified.

(ii) *Recommend*, where necessary, the kind of employment for which the workman is fit.

In cases of industrial disease the Board should:

(i) *Certify* the condition of the workman, including whether the disease was, in fact, contracted during the course of employment, and if so, the date on which the disablement commenced. The certificate of the Board should be conclusive and final evidence on the medical matters so certified.

(ii) *Recommend*, where necessary, the kind of employment for which the workman is fit.

Area: The normal areas for such Boards should be the county court areas, but the Home Office should be empowered to combine areas where this is deemed advisable.

Method of Appointment: The Home Secretary should set up an Advisory Medical Committee to assist him in the appointment of members of boards of referees, and also of certifying factory surgeons. The Advisory Committee should also assist in the selection of those practitioners claiming admission to the panel of experts.

17. The members of the Board should be remunerated on a sessional basis and should each receive a fee of six guineas for a half-day session or a fee of ten guineas each for a session extending to a full day, plus necessary travelling expenses.

18. The Committee is strongly of opinion that the proposed arrangements will effect a considerable saving in the total costs of compensation cases, but realizes that the expense of maintaining these boards will be considerably in excess of that involved in the present medical referee arrangements, and therefore considers it desirable that there should be safeguards to ensure that the Boards should not have referred to them frivolous or vexatious claims. It is accordingly proposed that where the workman or employer makes an application for the reference of a case to the Board of Medical Referees he should be required to pay an initial fee to the registrar. The Committee suggests that payment for the services of the members of the Boards of Medical Referees should be made by the State.

IV.—INDUSTRIAL DISEASES

Contested Cases of Industrial Disease

19. According to the Act, "where an employer or workman is aggrieved at the action of a certifying factory surgeon in giving or refusing to give a certificate of disablement or in suspending or refusing to suspend a workman for the purposes of Section 43 of the Act, the employer or the workman may, within ten days, make an appeal to the Registrar of the County Court for reference of the workman to a medical referee."

20. Experience has shown that the workman often fails to exercise his right of appeal because of ignorance of the steps to be taken in the short period of ten days. This applies particularly to the workman who is without the

advice of a trade union and, in some cases, because he is unable to bear the cost of an appeal.

The Committee suggests that the period should be extended to twenty-one days both for the workman and the employer, that notice of the right of appeal and the time in which it should be made should be clearly indicated on the statutory forms, and that the expenses of the appeal should be borne by the State.

PROCEDURE AND ARRANGEMENTS FOR ASCERTAINING AND SUPERVISING THE WORKMAN'S FUTURE PHYSICAL CONDITION

21. Under the present Act there is no special procedure for ascertaining the subsequent condition of a workman in receipt of compensation for a scheduled disease. It is recognized that a workman who has been *refused* a certificate of disablement may after a lapse of time apply for re-examination by the certifying surgeon either on the ground that his physical condition has altered or that he has again been exposed to the agent which gave rise to the disability. On the other hand, no provision is made for revision of a case in which a certificate of disablement has been *given,* although it not infrequently happens that new signs and symptoms arise showing that the original diagnosis was incorrect. It is held in the courts that if the disease from which a workman is suffering is the same as when certification took place, the certifying surgeon's certificate is still binding.

22. The Committee is of opinion that the present state of affairs in the above respect is undesirable.

It recommends that after a reasonable period has elapsed from the date of the original certificate of disablement or of the decision of the medical referee (where there has been an appeal) the workman or the employer may make a request for re-examination with a view to further ascertainment of the condition of the workman. Any such examination should be carried out by the certifying surgeon, and his decision should be subject to appeal to the Board of Referees.

The Committee also believes that it would be advantageous if certifying surgeons were given power to grant certificates of recovery from scheduled diseases, and such certificates might well include advice as to the wisdom of a workman returning to his former occupation.

V.—LUMP SUM PAYMENTS

23. The question of " lump sum " payments is a serious one and requires reconsideration. The Workmen's Compensation Acts provide for compensation by means of weekly payments, but also give the employer the right to commute such weekly payments by paying the redemption value, which is a sum fixed by the Act. The Acts, however, do not preclude the employer and the workman from agreeing to settle for a lump sum, and the only safeguard against the workman's agreeing this sum at an unduly low figure for the sake of obtaining an immediate cash payment is the requirement that the court shall approve the agreement. Sometimes the workman, in order to get a lump sum—for the purpose perhaps of launching out on some business prospect—may propose to accept a sum below the redemption value. If the employer puts this proposal before the court, it may, with due regard to all circumstances, sanction that arrangement. But under the present law a workman, unlike an employer, has no right to insist upon a lump sum settlement.

24. Where there is total permanent incapacity of the workman his position is protected by Section 13 of the Act, but the same degree of protection does not obtain where there is permanent partial incapacity. Some protection against an unsatisfactory settlement is afforded the workman, as a settlement may be made only through the registrar of the court. It is doubtful whether, in practice, this arrangement always affords the necessary protection, and the Committee draws the attention of the Departmental Committee to the desirability of a re-examination of the existing procedure with a view to rendering this scrutiny of proposed settlements more effective.

25. The view is widely current among members of the medical profession, especially those familiar with the practical working of the Workmen's Compensation Acts from its medical aspects, that the lump sum form of compensation is responsible for much prolongation of disability in a considerable number of cases. This is a very difficult question, and in some quarters the subject of great controversy, even after hearing the views of all concerned. The principle of lump sum compensation has been incorporated in statutory form in the Acts. Although employers and employees at a certain stage of the proceedings favour this method of settlement, from the medical point of view it is doubtful whether in many cases it is the correct method. The worker is in an unaccustomed atmosphere created by the many new and strange circumstances incidental to and consequent on his accident, and by the very fact of litigation. He may be burdened by anxiety and uncertainty as to his future earning capacity. There is evidence that undesirable " touts " from solicitors actually wait on accident cases to promote profitable litigation. The prospect of a large sum of money, larger than any he has ever handled, has a harmful effect on the mind of the workman. The delay in settlement leads to concentration on his compensation rather than on his restoration of function, and may even retard rehabilitation. These remarks are not to be interpreted as antagonistic to the workman's interests nor as attaching blame to him for the result. The fault lies in the atmosphere created by the working of the Act, without continued medical supervision, without co-ordination (as the Association's Fractures Committee demonstrated), and without rehabilitation schemes. Concentration should be on adequate treatment, supervisory encouragement, and rehabilitation rather than on lump sum compensation. The whole subject is one in great need of reconsideration.

26. This is not the place to discuss the disasters that result from the acquisition of a lump sum after a period of illness or the alteration in the social habits of the weekly wage earner that must result. In short, it may be said that the prospects of a lump sum may induce the patient to prolong an incapacity, and that it may disturb his whole social life to the detriment of himself, his family, and the State ; and the failure to receive the amount he was led to expect often leaves him embittered and disillusioned. The prevalence of unemployment aggravates the situation. Though the matter is one of considerable difficulty, it is suggested that this method of compensation should be reserved for permanently incapacitated workmen who have arrived at their minimum disability.

27. It not uncommonly happens that the money received as lump sum compensation is soon lost or dissipated because of business incapacity or lack of sound advice. The Committee suggests the establishment of advisory committees to assist workmen receiving these sums to employ them to the best advantage.

VI.—LIGHT WORK

28. One of the main difficulties experienced is the return of the convalescent man to work suitable for his physical condition. It is obvious that a man convalescent from an injury such as a fractured leg will not be unfit for his ordinary work one day and fit for it the next. There must be a time in his period of convalescence when he becomes fit for light work only, and when he would be materially benefited by the provision of such work. Large employers of labour should be able to assess with fair accuracy what percentage of the different categories of injury occurs annually among their employed, and it would seem possible that certain forms of occupation should be earmarked as suitable for convalescent or partially disabled workmen.

29. There is no legal definition of what constitutes " light work," and, indeed, it would be difficult to frame a definition that would cover each and every workman. In framing certificates under the Acts, however, the medical man has habitually to make use of the term, and its exact definition in the individual case frequently proves a stumbling-block.

30. The provision of light work for the disabled or convalescent man in the present industrial conditions reveals almost insuperable obstacles. Unless and until the injured workman is able to perform the full and complete work of his usual job his chances of employment are small. These chances, however, are greater if he is employed in a large workshop, and especially so if his employer (or the representatives of the employer) makes some effort to provide light jobs for the disabled man. The workman otherwise not only finds it difficult to obtain suitable employment, but is actually afraid to take up work that might prove too much for him and lead later to his discharge in favour of a man more physically fit, there being no dearth of substitutes in the present state of the labour market. The position is further complicated by the fact that, owing to the war, there is at present in this country an abnormal number of disabled men who may have been given special or light work, and whom it would be unfair to displace..

31. In the view of the Committee the problem can be dealt with satisfactorily only by the establishment of rehabilitation units. The provision of these would effect an improvement from every point of view, and would considerably reduce the amount of compensation both claimed and paid. These rehabilitation centres should have a twofold object: to provide temporary light work, enabling a man to fit himself for his ordinary pre-accident work, or to provide a permanent alternative occupation for the permanently disabled.

APPENDIX V

REPORT OF COMMITTEE ON THE COMPULSORY USE OF YELLOW LIGHTS FOR MOTOR CARS

The committee consisted of Professor Sir Joseph Barcroft (Cambridge), Sir John Parsons (London), Mr. N. Bishop Harman (London), Dr. John Aydon (London), Dr. R. J. Lythgoe (London).

The committee discussed the report of a committee of the French Ministry of Public Works dated December 26th, 1935 (Headlights Committee of the Central Committee on Motor Vehicles and General Circulation), drawn up by M. H. Dauvergne, Engineer-in-Chief of Mines, and issued from the Ministry of Public Works, Paris. The Paris committee recommended to the French Government that the use of yellow light in motor car headlamps should be made compulsory.

In the Paris report it is claimed that " yellow light " is superior to white light for use in motor headlamps for the following reasons:

(1) Improvement in visual capacity (Acuteness of Vision for Detail ; Appreciation of Differences of Brightness ; Speed of Vision, etc.).

(2) It causes less annoyance to other road users, both when the headlamp is in view and during recovery from glare after the car has passed.

(3) In fog and rain the advantages of yellow light are incontestable.

It is not clear from the report of the Paris committee whether reference is made to monochromatic yellow illumination such as is produced by a sodium-discharge tube or to the yellow illumination produced by filters which is usually white light minus blue.

The committee of the B.M.A. wish to make the following observations on the Paris report:

(1) *Improvement in Visual Capacity*

A considerable amount of work has been done on the relation between visual capacity and the wave-length of the illuminant. So far as purely optical conditions are concerned visual acuity should be considerably improved by monochromatic light. On the whole the expectations of improved vision under these conditions have not been realized.

Acuteness of Vision for Fine Detail.—The interposition of colour filters in front of the source of illumination always causes a lowering in the visual acuity. If, however, one compares the acuteness of vision for a white and a pure yellow illumination after their intensities have been equalized, one finds that yellow light is slightly superior to white. The effect is, however, very small, and involves long and patient experiments in the laboratory for its certain detection. (Lythgoe, M.R.C.Spec. Rep. No. 104, 1926, for a general review; Luckiesh, *Trans. Ill. Eng. Soc. Amer.*, Vol. 7, p. 135, 1912, etc. ; Bell, *Elecr. World,* Vol. 58, p. 637, 1911). This result was not obtained by Ferree and Rand using mixed coloured light (*Ann. Ophthalmol.*, Vol. 25, p. 447, 1916, etc.).

Appreciation of Differences of Brightness Contrast.—There has been a considerable amount of research on the appreciation of contrast at different wave-lengths owing to the importance of the problems in photometry. The classical work of König and Brodhum (1888–9) showed that at comparatively high illuminations there was nothing to choose between the different colours of white (see König, *Gesammelte Abhandlungen,* Leipzig, 1903). At low illuminations there is some indication that yellow is inferior to all colours except red, but it is possible that insufficient attention was paid to the relative brightnesses of feeble colours. (König, *Physiologische Optik,* Leipzig, 1929, for a general account of this and other work.) More recently Troland has given the colours the following order of merit: green, yellow, red, blue (Troland, *Psychol. Rev.*, Vol. 25, p. 359, 1918).

Speed of Perception.—The B.M.A. committee knows of no direct evidence of the dependence of speed of perception on wave-length, but the evidence derived from the critical frequency of flicker indicates that the essential factor is the brightness of the colour in the range of illuminations under consideration (see Parsons, *An Introduction to the Study of Colour Vision,* Cambridge, 1924).

Perception of Colour.—One of the most important factors in the visual recognition of objects is that of colour. It often happens that an object on a road illuminated by a motor car's headlights has the same apparent brightness as the background. Usually such an object is recognized by the difference in colour between itself and its background. When this colour difference is absent, or when the object is illuminated by monochromatic light, it becomes invisible. So far from accentuating certain tints, as it is claimed to do in the Paris report (b, 2), yellow light would be expected to rob the eye of one of its most important aids in the recognition of objects. There is, for instance, great difficulty in recognizing the colour of the globe of a Belisha beacon under the yellow illumination of a sodium discharge tube.

(2) *The Annoyance Caused to other Road Users*

It is claimed in the Paris report that this is less with yellow light than with white. If a yellow glass were placed in front of an oncoming headlight this would undoubtedly be true, because the intensity would be less. The B.M.A. committee knows of no evidence which would support the contention with equal intensities of illumination.

The report of the Paris committee also contains a number of statements which require further explanation,

Under the heading " Reduction of Dazzle " it is implied that yellow light is less dazzling because the peripheral retina is less sensitive to this wave-length. This is partially true, but it should also be stated that yellow light will be less effective in providing the requisite stimulation of the peripheral retina for the ordinary purposes of vision.

The Paris report also states that yellow light causes less contraction of the pupil than white light. This statement must refer to a yellow of less intensity than the white, since it is well established that coloured lights of equal apparent brightness cause equal amounts of contraction of the pupil (Sachs, *Pflügers Arch.*, Vol. 52, p. 79, 1892, Abelsdorff, *Ztsch. Psychol.*, Vol. 21, p. 451, 1900).

The Paris committee is apparently unaware of the recent important work of Wright (*Proc. Roy. Soc.*, B, Vol. 115, p. 49, 1934) on the recovery of vision after exposure to bright lights of different wave-length. Here it is stated that the return of colour sensitivity is much the same for all colours except for blue, where the recovery is more rapid.

The B.M.A. committee knows of no work on the persistence of after-images produced by light of different wave-length where intensity has been adequately controlled.

(3) *Fog and Rain*

The Paris committee states with assurance that in fog and rain the advantages of yellow light are incontestable. In theory a very slight improvement might be expected with light of long wave-length ; in practice, however, this difference does not exist. The following passage is quoted from a report on some work done at the National Physical Laboratory in order to investigate this point:

" To sum up, as far as the determination of headlight range in fog by the present method enables us to judge, the revealing power of a coloured beam is the same as that of a white beam of the same intensity."

" Although this represents the unambiguous conclusion of the experiments, the possibility cannot be excluded that for some special type of fog, not met with in the measurements, the result as stated may no longer hold good."

(Stiles, *Illuminating Engineer*, Vol. 27, p. 313, 1934.)

Omnibuses in this country frequently carry fog lights with a deep amber glass. The evidence of the drivers themselves shows that some men prefer a white fog light, others prefer a yellow, others again prefer no fog light at all.

Conclusion

In conclusion, it appears to the B.M.A. committee that the Paris committee has made extravagant claims for the superiority of yellow headlights over the ordinary " white " variety. With the possible exception of an improvement in visual acuity for very small objects, previous research work shows that yellow illumination is not superior to white illumination of equal candle power. Under the conditions of illumination on roads at night the acuteness of vision for small objects probably plays a relatively small part in the whole visual picture.

Yellow illumination must be definitely inferior to white in the recognition of objects by their colour. The fact remains that many drivers do prefer a yellow light apart from the lower intensity of illumination. These preferences are probably psychological.

The available evidence on the subject is not sufficient for the B.M.A. committee to make definite recommendations in any direction. There are no grounds for taking legislative action.

APPENDIX VI

MEMORANDUM REGARDING A NATIONAL MATERNITY SERVICE FOR ENGLAND AND WALES

1. The policy of the British Medical Association as to the form which a Maternity Service should take was laid down in a Memorandum outlining a National Maternity Service Scheme for England and Wales which received the approval of the Annual Representative Meeting in July, 1929. Since then the subject of maternal mortality has received much public attention. Local authorities, at the instance of the Ministry of Health, have developed their service in relation to maternity along local lines, and several bodies have made suggestions for attacking the problem both by national and by local measures.

2. At the outset the Council of the Association desires to endorse the views expressed by the Annual Representative Meeting, 1935 (Minute 115), in the form of the following resolution—namely:

> " That the British Medical Association regrets that the question of maternal mortality has become the subject of widespread political discussion, receiving great publicity in the lay press. Maternal mortality is a scientific and administrative problem which deserves careful and scientific study, but, in the experience of practising doctors, the publicity which it is receiving to-day is tending to terrify child-bearing women, and is, in itself, a cause of increased mortality."

In this connexion it may be noted that in a Scottish official report, to which further reference will be made (para. 6), the writers say:

> " There has been an unfortunate tendency of late to over-emphasize the danger of child-bearing, and it is desired to take this opportunity to stress publicly the facts that pregnancy and parturition are natural physiological processes, and that departures from the normal occur only in a small proportion of cases. It is difficult to assess the reactions caused in women by fear unnecessarily aroused by indiscreet public emphasis on accidents of child-bearing. There is no suggestion that scientific inquiry should be discouraged, but it is believed that disproportionate publicity of untoward results may itself aggravate a problem already sufficiently difficult."

Without any desire to minimize the importance or extent of the problem of maternal mortality the Council believes that these things required to be said, and it ventures to hope that they will have their due effect.

3. It desires also to direct attention to a certain laxity in the use of terms in relation to this subject. Writers compare rates of mortality as between different types of practice in this country, and also as between this and other countries, which are not calculated in the same way and have no common basis of recording. The basis of the rates used may be total births, or live births only or actual confinements. The deaths may or may not include deaths from abortion, but the total number of cases of abortion against which they ought to be placed is never known. The term " maternal mortality " may or may not include deaths due to causes associated with pregnancy, parturition, or the puerperium, but not directly due to this state. The number of the women confined who belong to different degrees of parity is not usually known, so that the mortality in each group cannot be stated. In classifying deaths to their causes differences of personal opinion may vitiate comparison, and this is especially true of certain estimates of the proportion of maternal deaths which belong to the " avoidable " class. The Registrar-General for England and Wales uses the term " puerperal mortality rate " to describe the number

of deaths due to diseases of pregnancy, childbirth, and the puerperal state per 1,000 registered births (live or dead), and the Council thinks that this terminology should be used by all who write on the subject. The Registrar-General also gives a rate which includes not only these deaths but also deaths from causes not classed to pregnancy or child-bearing but occurring in association with that state (such as influenza, pernicious anaemia, mitral valve disease, etc.). For purposes of distinction this inclusive rate may conveniently be called the " maternal mortality rate." Stillbirths have been registrable only since 1928, so that, for comparison with earlier years, the denominator of the ratio has to be taken as the number of live births only. In Scotland, where stillbirths are not registered, the latter method has to be adopted. The point the Council wishes to emphasize is that writers and commentators who refer to rates of mortality in pregnancy and child-bearing should be very certain that the rates they quote are truly comparable.

4. The Council, in its brief references to statistics, confines itself to those provided by official publications, for they are sufficiently illuminating. As a proportion of the total deaths, those due to maternity form a small fraction. During the ten-year period 1924–33, 4,805,021 persons died from all causes in England and Wales, of whom only 27,664 or 0.56 per cent. were attributable to the puerperal state. The comparison would be more just if deaths of women between the ages of 15 and 50 years only were used. If this is done, it is found that puerperal deaths amounted to 27,645 in that decennium among 434,652 deaths of women at those ages from all causes, a percentage of 6.36. Although many of the public statements about puerperal mortality have been unwise and have tended to exaggerate the seriousness of the problem, it is indisputable that the loss of so many lives of women in the prime of life, when their survival is a matter of the first moment to their families and the community, calls for any social and professional action that is likely in practice to lead to betterment. It was with this object that the Association prepared its Scheme in 1929.

5. The trend of maternal mortality since that date is shown in the following table, taken from the Annual Report for 1934 of the Chief Medical Officer of the Ministry of Health.

England and Wales: Maternal Mortality per 1,000 Total Births

	Puerperal Sepsis	Other Puerperal Causes*	Total Puerperal Mortality*	Non-Puerperal Causes	Total Mortality*
1928	1.72	2.52	4.25	1.15	5.39
1929	1.73	2.43	4.16	1.43	5.59
1930	1.84	2.38	4.22	1.14	5.36
1931	1.59	2.35	3.94	1.38	5.32
1932	1.55	2.49	4.04	1.11	5.15
1933	1.75	2.57	4.32	1.37	5.69
1934	1.95	2.46	4.41	1.20	5.61

* Not including criminal abortion.

It will be seen that, during 1928–31, tendency of the puerperal and mortality rates was, if anything, downward. In 1932–4 the puerperal mortality rate was 4.04, 4.32, and 4.41 respectively—that is, substantially higher in the last two years than in any of the years since registration of stillbirths. When the rates are calculated on *live* births alone, as is necessary for comparison with earlier years, they are found to have remained fairly constant from 1911 until 1932, with a period of rather lower mortality from 1921 to 1925, followed by a rise to a maximum in 1928 (puerperal mortality 4.42, maternal mortality 5.62 per 1,000 *live* births), and a slight fall up to 1932 (the respective rates being 4.21 and 5.37 per 1,000 *live* births).

Maternal mortality, then, is not falling. Judged by the puerperal mortality rate per 1,000 total births in 1933 and 1934, it is now as high as it has ever been. The Registrar-General's analysis (1932) indicates that some areas, such as urban districts, certain regions in the North, and the whole of Wales, experience exceptionally high rates. Puerperal sepsis figures more heavily as a cause of death in most of these areas, and indeed in all towns except London. A high rate seems to be associated with correspondingly high stillbirth and neo-natal mortality rates. The recent Scottish report mentions striking variations of the rate as between different areas of that country.

6. Among the contributions to the elucidation of the problem which have received most attention both from the public and from the medical profession, the reports of a Departmental Committee on Maternal Mortality and Morbidity appointed by the Minister of Health[1] are specially deserving of mention. In the course of its deliberations that Committee investigated the circumstances surrounding the deaths of 5,800 women in pregnancy and childbirth, and concluded that at least one-half of them could have been prevented. The danger of accepting this decision as definite has been referred to in para. 3, but the report must be regarded as representing the views of medical men and women well qualified to judge, within the limits of the investigation which they were able to undertake. The Committee's recommendations included improvement in the training of medical students, the provision of facilities for post-graduate study, the exclusion of " handy-women " from taking part in midwifery, improvement in the pre-certificate and post-certificate training of midwives, continuous ante-natal care by the attendants who will be responsible for the delivery, improvement in the provision and management of maternity hospitals, and the establishment for all pregnant women of those services of qualified medical practitioners, certified midwives, consulting specialists, and ancillary assistance which the Association has advocated in its Scheme.

The results of a special investigation carried out in 1933 by the Association through private practitioners were not essentially different, although the rates of mortality in this practitioners' group of cases were definitely lower than those for the whole country. Many even of these keen practitioners evidently found it difficult to secure adequate ante-natal care for their patients under the conditions of private practice, without the additional opportunities which the Association's Scheme would afford. A recent inquiry in Scotland, conducted for the Scientific Advisory Committee of the Scottish Health Department by Drs. Douglas and McKinlay,[2] has led to similar conclusions. The writers emphasize the importance of continuous ante-natal, intra-natal, and post-natal care by the same medical attendant, and the need for local authorities to assume the responsibility of providing such assistance as may be necessary. Incidentally it may be mentioned that an analysis of more than two thousand maternal deaths in New York, made by the Academy of Medicine Committee on Public Relations in 1933, indicated that about 66 per cent. of these deaths might have been avoided. The number of births on which these figures were based was 348,310, of which 102,105 occurred in the home and 246,205 occurred in hospital. Domiciliary confinements suffered a mortality rate of 1.9 per 1,000 and hospital confinements a mortality rate of 4.5. It is pointed out in the report of that Committee that this difference may be partly accounted for by difference between the types of cases treated and the types of delivery undertaken. After an examination of the various factors, the Committee summarizes its view in the following paragraph:

> " The hospital is and will remain the only proper environment for the care and management of the abnormalities of pregnancy, labour, and delivery. The great increase in the hospitalization of the normal parturient

[1] Interim Report of Departmental Committee on Maternal Mortality and Morbidity, 1930, and Final Report, 1932.

[2] Report on National Morbidity and Mortality in Scotland, 1935, by Charlotte A. Douglas, M.D., D.P.H., M.C.O.G., and Peter L. McKinlay, M.D., D.P.H.

has failed to bring the hoped-for reduction in puerperal morbidity and mortality, and this in spite of great advances in our knowledge of the processes involved and the proper way of treating them. It would seem that the present attitude toward home confinement requires re-examination, and a programme looking toward an increase in the practice of domiciliary obstetrics deserves careful investigation."

7. Actuated no doubt by a sense of the failure of the puerperal mortality rate to decline and by the recommendations of the Departmental Committee, the Minister of Health has urged local authorities to develop their provision for women in pregnancy and childbirth, particularly in circulars issued in December, 1930 (with a memorandum on ante-natal services) and October, 1934. The expansion of these services may be measured by the following statistics taken from the Annual Reports of the Ministry of Health. They refer to England only.

	1931	1932	1933	1934
Notified births (live or dead)	582,055	571,012	543,623	559,918
Ante-natal clinics	1,193	1,277	1,330	1,396
Number of women attending	197,269	222,077	229,549	241,144
Women attending per 100 births	33.89	38.89	42.23	43.07
Total attendances	704,722	793,815	842,503	931,878
Maternity beds in institutions plus local authority rate-aided beds in voluntary institutions	6,856	7,119	7,245	7,610
Number of admissions to beds described above	95,587	105,897	113,392	123,147
Admissions to beds described above per 100 notified births *	16.4	18.5	20.9	22.0

* In calculating these percentages women sent to other institutions by local authorities have not been included; they numbered 8,799 in 1932, 9,370 in 1933, and 11,125 in 1934.

8. It will be observed that recent years, during which the puerperal mortality rate has failed to decline but has rather shown an upward tendency, have been signalized by steadily growing provision for ante-natal clinics and hospital accommodation by local authorities and by an increasing acceptance of that provision by women. In spite of the increase in ante-natal care and the diminishing number of births the number of deaths from eclampsia is rising. The Council has too lively an appreciation of the complexities of the problem to draw crude comparisons from statistics of this kind, but it desires to point out that the increased risk of puerperal infection when large numbers of women are aggregated together in hospitals must be recognized. The Association has maintained that ante-natal care by medical practitioners who will not be in attendance upon women in childbirth and the puerperium is unlikely to be successful.

9. The Council holds most strongly to the opinion that no national maternity scheme has any prospect of success unless it is based upon the principle of continuity of medical and nursing care throughout pregnancy, labour, and the puerperium. It is recognized that this object may be attained in two ways. Long and careful consideration has been given to them.

(A) It is suggested in some quarters that the services of a staff of obstetric specialists, providing ante-natal, intra-natal, and post-natal care should be engaged for the conduct of all State-aided and rate-aided maternity services. These specialists would engage in no field of medical practice other than obstetrics and gynaecology. The main arguments put forward in support of such a scheme may be briefly summarized as follows:

(i) In recent years there has been a considerable increase in the number of women seeking to be confined in institutions. The case for this form of maternity service is based on the assumption that the further institutionalization of maternity is inevitable and that it is at least as safe as domiciliary confinement in respect of infection.

(ii) As midwifery is in many areas passing out of the hands of the general practitioner he is failing to obtain that continuous post-graduate experience which is necessary to enable him to deal effectively with the emergencies to which midwives have to summon him.

(iii) It is contended that obstetric specialists responsible for the supervision of the ante-natal care of midwives' cases and attending a number of cases throughout would give a more competent service, with the result that maternal mortality would decline and maternal health generally would improve.

(B) There are substantial arguments against the proposal outlined in paragraph 9 (A) and in favour of a service in which the general practitioner plays a prominent part. They may be summarized as follows:

(i) The proposal of a special service is based on the assumption of an increasing tendency towards institutionalization and on the further assumption that this tendency is inevitable and advantageous. That such a tendency exists cannot be gainsaid, but it does not follow that it is in the interests of the community. There is ample evidence that institutional confinement carries with it a greater danger of infection than domiciliary confinement. In certain towns, where both hospitalization and ante-natal work have increased, the figure for maternal mortality has either remained practically unaffected or even shown a rise. In these circumstances it may well be argued that the tendency towards institutionalization should be resisted on the ground that it will not help to reduce maternal mortality and morbidity, but will in all probability tend to increase them. A method of organization based on institutionalization is unsound and unlikely to secure increased efficiency of medical service.

(ii) In view of the fact that the financial arrangements of local authorities and others making this provision are playing an increasing part in persuading women to leave home for their confinements, the Council believes that there is a need for widespread public education on the advantages and the safety of domiciliary confinement.

(iii) In recent years the general practitioner in the larger towns has been separated to an increasing extent from midwifery; but there has been no corresponding decline in maternal mortality in these towns. Experience in these areas does not justify the extension of schemes involving the divorce of the general practitioner from midwifery. Further, it should be borne in mind that, taking the country as a whole, the general practioner bears a heavy responsibility still in that he is called in, or remains liable to be called in, to over 400,000 births a year. The supersession of the general practitioner has been relatively intense only in the large towns. Although the *average* number of maternity cases attended by practitioners has fallen low in these towns, this figure does not give a true picture of the actual state of affairs as the cases are not evenly distributed, the bulk of them being undertaken by practitioners who, being interested in midwifery, undertake not inconsiderable numbers of cases. That all too commonly such a practitioner is called in to an emergency without having had the opportunity of undertaking the ante-natal care of the mother makes his responsibility, in many cases, much heavier.

The incident of pregnancy should not be the signal for the transference of a woman from the care of one practitioner to another, for care during pregnancy and labour should be continuous with the normal medical care under the general practitioner. Maternal mortality is not attributable to one clearly defined factor which will be absent from a special maternity service of the kind described above. A specialist in sole charge of the patient who is without full personal knowledge of her medical history will be imperfectly equipped for her care during pregnancy, labour, and the puerperium. An illness occurring before a confinement may have an important bearing on it, while subsequent and related disorders may, in turn, affect the general health of the mother. For these closely related conditions the general

practitioner must continue to be responsible. The birth of a child is not a mere mechanical event unrelated to the life-history of the mother.

10. Domiciliary midwifery as practised to-day affords a field for improvement in conditions vitally affecting the well-being of three-quarters of the mothers of the country which has hardly been touched during the campaign to reduce maternal mortality and morbidity. So far only one whole-hearted effort has been made, that in Rochdale, and there the results were, to say the least of it, encouraging.

Many of the adverse circumstances in this sphere of practice are not inherent, but can be mitigated or eradicated. Were general practitioners to be made responsible for the ante-natal care of midwives' cases they would be able during pregnancy to instil confidence into the minds of these women, which would render them more prone to follow the doctor's advice should the labour prove to be prolonged or otherwise abnormal. Were a competent midwife present in every doctor's case he would be saved much anxiety and many unnecessary and tiring calls. Were he able to remove a patient to hospital and continue in attendance, if necessary with the co-operation of the specialist, he would be enabled to undertake certain operations in more suitable surroundings, and the patient would be less likely to object to removal. These few examples show how materially the clinical work of general practitioners in conducting domiciliary midwifery can be bettered. There are also opportunities by means of improved midwives' service, provision of "home helps," etc., to ameliorate the home conditions and so retard, if not reverse, the quite recent tendency of women to seek admission to hospital for their confinements for purely social reasons or by reason merely of financial inducement.

The argument has been used that general practitioners taken as a whole are not sufficiently expert to be trusted to practise midwifery unless they undergo a practical course of post-graduate teaching on the subject. The Council is of opinion, however, that *the most frequently needed forms of intervention* do not require more skill than has been attained by the vast majority of general practitioners, or than can be achieved by medical students during the extended period of training which has now been laid down by the General Medical Council. It is rather the judgement to decide when to intervene or whether to intervene at all that is required for good midwifery practice. General practitioners have day by day to decide cognate questions in their medical and surgical practice, and they therefore become skilful in this most difficult art. Nevertheless, the Council considers that the wisdom of calling in a consultant or removing the patient to hospital in certain specially difficult cases is not sufficiently appreciated.

11. The Council has come to the conclusion that continuity of medical care should be secured by the provision in any national maternity service of a general practitioner and a certified midwife for every maternity case. If the training of the medical practitioner in this branch of practice can be shown to be defective the remedy lies in its reorganization and improvement. All available evidence suggests that the institution is not safer than the home, and in the view of the Council the remedy for the existing situation lies, not in a more complete separation of the general practitioner from midwifery, but in a full recognition of his position as the person responsible for the continuous care of the mother. This means that steps should be taken to increase the number of maternity cases which the general practitioner will attend rather than to encourage the present tendency to diminish it. General practitioners should be sufficiently equipped to know how to deal with obstetric emergencies, and this can only be achieved if they remain in effective and practical touch with midwifery.

12. Merely to reform the practice of midwives, however desirable it may be, will not remedy the present chaotic system. If new legislation is contemplated it should aim at the establishment of a complete maternity scheme on the lines recommended by the Association.

13. The scope of an efficient maternity service should be that embodied in the Association's Scheme. It is set out below in a form slightly modified from that in which it appeared in the Association's Memorandum of 1929:—

(1) Efficient ante-natal care by, or under the responsibility of, a medical practitioner throughout pregnancy in every case;

(2) Attendance in every case by a certified midwife during the ante-natal period, labour, and the puerperal period;

(3) Attendance by the practitioner chosen by the patient during pregnancy, labour, and the puerperal period, when, as a result of his ante-natal examination, the practitioner has declared his personal attendance to be necessary, or when his attendance is requested by the midwife;

(4) The provision in every case of at least one post-natal consultation between the patient and the practitioner (including, if necessary, examination);

(5) The services when necessary of a second practitioner (for example, to administer anaesthetic);

(6) The services of a consultant when considered necessary by the practitioner;

(7) The provision of laboratory services when considered necessary by the practitioner;

(8) The provision of beds for such cases as in the opinion of the practitioner require institutional treatment; treatment in the institution being, as far as possible, continued by the same practitioner;

(9) Supply of sterilized obstetric dressings in every case;

(10) Provision of ambulance facilities for patients requiring to be removed to institutions;

(11) The provision of "home helps" (i.e., women trained in domestic work), who would relieve the mother of the worries of domestic management during the lying-in period.

14. The Council believes that the best method of providing a maternity service of this kind is through an extended system of national health insurance as outlined both in the Association's Memorandum of 1929, to which reference has been made, and in the Association's "Proposals for a General Medical Service for the Nation," adopted by the Annual Representative Meeting in 1930 (Section VIII, p. 41). It is recognized, however, that until such a scheme comes within the range of practical politics local authorities will desire to develop their provision within existing statutes. Development along the lines suggested above is permissible under existing law, subject to the approval of the Minister of Health, and the Council suggests that this is the line of advance which local authorities should be urged to adopt.

15. The Council is of opinion that the Association's Memorandum outlining a National Maternity Service for England and Wales (1929) should be adhered to, with such variations as are indicated in this report. As the financial arrangements suggested in that report are now not fully applicable they have not received consideration.

16. The Council reiterates the Association's view that undergraduate and post-graduate education of medical practitioners in all medical subjects, including midwifery, should be improved. The fact that the General Medical Council has already taken action so far as undergraduate education is concerned is a further argument for reversing the present tendency to exclude the general practitioner from the care of pregnant and parturient women. The Council calls attention to the declaration in the Memorandum of the Association of 1929 as to the advantage of *periodic* post-graduate education for practitioners co-operating in a National Maternity Service. In the same year the Departmental Committee on Maternal Mortality reported that "post-graduate facilities for doctors are inadequate." Though there has been some improvement since then it is still difficult, from lack of time or from financial considerations, for many practitioners to avail themselves of such facilities as exist. It may not be outside the bounds of possibility for some financial arrangements to be made which would facilitate the obtaining of this advantage.

APPENDIX VII

REPORT OF THE COMMITTEE ON MEDICAL ASPECTS OF ABORTION

I. PRELIMINARY

1. In 1933 the Representative Body of the British Medical Association requested the Council of the Association to report upon the desirability of setting up a special committee, including members of the legal profession, to consider the case for the amendment of the law relating to abortion. During the discussion at the Annual Representative Meeting, 1933, two main arguments were put forward in support of this proposal. It was stated, first, that medical practitioners were unwilling to perform therapeutic abortion—that is, abortion for medical reasons—owing to their sense of legal risk arising from the uncertain state of the law ; and, secondly, that the medical profession should endeavour to guide public opinion, which was becoming more and more interested in this question.

2. The Council presented its report to the Annual Representative Meeting, 1934. In this report, while questioning the alleged uncertainty of the medical practitioner as to his freedom to perform therapeutic abortion, the Council stated that if any real uncertainty existed on this point it might be well to get it resolved. On the question of guiding public opinion, the Council, after pointing out that abortion was not solely a medical problem but one which was related also to the criminal law and to social, economic, ethical and religious standards and opinions, proceeded to express the following view: "While medical practitioners as citizens are entitled to hold individual opinions and cultivate activities on these several issues the medical profession as such has no special right and no special competence to deal with them, and the Council therefore considers that any proposal that the profession ought to lead public opinion in such questions is one to be resisted. The medical profession in its corporate activities will best preserve its influence by keeping within the boundaries fixed by the particular expert technical knowledge of its members. If for legal, social, economic, ethical, or religious reasons an inquiry on abortion is advisable, it is for those directly concerned to incur the responsibility and expense."

In concluding its report the Council recommended:

> "That while the Association would be willing to contribute expert medical assistance and/or evidence to any committee set up by the Government to examine the various relations of the practice of abortion, the Association is of opinion that the subject has predominating interests other than medical, and that the initiation of the proposed inquiry does not properly fall within the responsibilities of the medical profession."

3. The Annual Representative Meeting, 1934, adopted the above recommendation in the following amended form:

> "That the Association would be willing to contribute expert medical assistance and/or evidence to any committee set up by the Government to examine the various relations of the practice of abortion."

4. At the same time the Annual Representative Meeting requested the Council to set up a special committee "to consider and report upon the medical aspects of abortion." Accordingly a special committee with this reference was appointed by the Council on July 25th, 1934, and reappointed on July 23rd, 1935.

5. Constitution of Committee. The committee was constituted as follows:

James Young, D.S.O., M.D., F.R.C.S.Ed., F.C.O.G., London (*Chairman*).
R. G. Gordon, M.D., D.Sc., F.R.C.P.Ed., Bath (*Deputy Chairman*).
H. S. Souttar, C.B.E., D.M., M.Ch., F.R.C.S., F.R.A.C.S., London (*Chairman of Representative Body*).
E. Kaye Le Fleming, M.D.(Hon.), M.B., B.Ch., Wimborne (*Chairman of Council*).
N. Bishop Harman, LL.D., F.R.C.S., London (*Treasurer*).
T. W. Naylor Barlow, O.B.E., M.R.C.S., L.R.C.P., D.P.H., Wallasey.
Aleck W. Bourne, M.B., B.Ch., F.R.C.S., F.C.O.G., London.
H. L. Hatch, M.B., M.R.C.S., L.R.C.P., Pinner
Sir Ewen Maclean, F.R.S.Ed., P.C.O.G., M.D.(Hon.), F.R.C.P., Cardiff.
Sydney A. Smith, F.R.S.Ed., M.D., F.R.C.P.Ed., Edinburgh.
Dorothea E. Walpole, M.B., Ch.B., Edinburgh.

II. GENERAL CONSIDERATIONS

6. Having regard to the circumstances in which it was appointed, the committee decided to omit from its survey such clinical matters as the technique of inducing abortion. It has also regarded abstract and specific questions of economics, equity, morality, and religion as being outside the scope of its inquiry. While it could not entirely exclude from its purview all questions which have legal, economic, ethical, or religious bearings, it has confined its attention to matters with which the medical practitioner is concerned in the course of his professional work.

7. The term "abortion" is now generally applied to include all cases of expulsion of the foetus before the age of viability—that is, before twenty-eight weeks, or seven lunar months. The former practice by which "abortion" was restricted to expulsion up to and including the sixteenth week and "miscarriage" to expulsion from the sixteenth to the twenty-eighth week, is now generally discarded in medical phraseology.

8. The frequency of abortion has been variously estimated. It is, at the outset, clear that on a matter of this nature figures of accurate statistical value are difficult to obtain. It is well known that in many instances early abortion produces such slight clinical manifestations that its occurrence easily escapes notice. It may not be recognized by the patient herself, and it may be regarded by the doctor as merely implying a disturbance in the menstrual rhythm. There are many instances also in which abortion after two or even three months' amenorrhoea may occur without producing clinical manifestations sufficiently marked to necessitate the attendance of a medical practitioner. It is notorious also that where there has been unlawful interference expert advice may be called only in the event of untoward symptoms developing. For all these reasons it is obvious that there are very great difficulties in any attempt to assess the frequency of abortion, and any statistics prepared with this object in view must necessarily possess only an approximate value.

9. It is generally reckoned that in this country from 16 to 20 per cent. of all pregnancies end in abortion. Beckwith Whitehouse, in an investigation of 1,148 women, found that the ratio was 1 abortion to 4.8 labours. Munro Kerr gives figures for Glasgow, which are lower than those which generally obtain. In an analysis of 500 women he found that there were 1,376 children and 191 abortions—that is, approximately 1 abortion to 7 labours.

10. The relative proportions of abortion which are due, on the one hand, to accident and disease—that is, "spontaneous" abortion—and, on the other hand, to intentional and unlawful interference, are impossible to estimate with

any degree of accuracy. The main reasons for this are sufficiently obvious when it is remembered that it is often difficult or impossible under ordinary conditions to obtain admission of an unlawful intent. Even where, as in some published hospital records, information on this question is forthcoming, the data are subject to the criticism that clinical material of this kind is for obvious reasons apt to be selectively overweighted by a preponderance of the serious—that is, the unlawful—cases.

11. Attempts have been made with varying success to obtain data of statistical value in regard to the frequency of spontaneous abortion. Thus, for example, Bluhm made an investigation into the family history of clergymen in Germany. The investigation of this selected community, it was felt, was more likely to be free from those complicating issues associated with unlawful interference which obtain in the general community. It was found that the abortion rate in a total of 186 conceptions so studied was 7.5 per cent., with a possible error of ± 2 per cent. due to the smallness of the figures. It is true that these figures relate to a more or less sheltered section of the population, and that it would be unwise to employ them for purposes of general application. Nevertheless they do suggest that spontaneous abortions constitute a relatively small proportion of the total. This is borne out by the investigations of Bumm, who in unselected groups found a spontaneous rate of 5 per cent. These figures are quoted from Freudenberg.*

12. The high degree in which abortion in this country is contributing to the maternal death rate is recognized as constituting a public health problem of great gravity. The Departmental Committee on Maternal Mortality and Morbidity (1932) showed that of maternal deaths directly due to child-bearing 13.4 per cent. were caused by abortion. The dominating cause of the fatal issue in abortion is sepsis; during the years 1930–2 this factor was responsible for 72.5 per cent. of the abortion deaths. It is well known that the majority of these sepsis deaths occur in cases of an unlawful nature. This will be dealt with more fully under a subsequent heading (para. 42).

13. Intimately bound up with this aspect of the subject is the question as to whether there is any evidence of an increase in the frequency of abortion. The data in regard to this matter are uncertain and conflicting. The figures of Beckwith Whitehouse, who found that the abortion rate in a large group of women investigated in the post-war period did not differ materially from a similarly large pre-war group, and those of Malins of thirty years ago, who then found an abortion rate of 1 in 6, tend to argue against any such appreciable increase. In contradistinction to such evidence we have, however, the statements of the Ministry of Health, which show that since 1930, when abortion deaths constituted 10.5 per cent. of the maternal mortality, there has been a steady rise to a percentage figure of 16 in 1933. The committee, further, has received evidence which suggests that within the past decade there has been an increase in abortion of an unlawful nature. This subject will receive fuller consideration in a subsequent paragraph.

14. A consideration of abortion in its relation to the doctor raises issues of a manifold character, with all of which he is concerned in varying degrees. In addressing itself to this subject the committee has regarded itself as called upon to deal especially with the view, which is often expressed, that the existing state of the law renders the circumstances governing therapeutic abortion unsatisfactory both to the doctor and to the best medical interests of his patients. The committee has, in addition, given attention to those aspects of unlawful abortion which more especially concern the medical profession in its capacity as the guardian of the nation's health.

It is found convenient to discuss these questions under the following headings:

The law relating to abortion as it affects the medical profession.

The indications for therapeutic abortion.

The medical aspects of the problem of criminal abortion.

* Freudenberg, K.: Berechnungen zur Abtreibungsstatistik, *Zeit. f. Hygiene und Infectionskrankheiten*, 1925, civ.

III. THE LAW RELATING TO ABORTION AS IT AFFECTS THE MEDICAL PROFESSION

The Law in this Country

15. The law concerning abortion is set out in Sections 58 and 59 of the Offences Against the Person Act, 1861:

"58. Every woman, being with child, who with intent to procure her own miscarriage, shall unlawfully administer to herself any poison or other noxious thing, or shall unlawfully use any instrument or other means whatsoever, with like intent, and whosoever, with intent to procure the miscarriage of any woman, whether she be or be not with child, shall unlawfully administer to her or cause to be taken by her any poison or other noxious thing, or shall unlawfully use any instrument or other means whatsoever with the like intent, shall be guilty of felony, and being convicted thereof shall be liable, at the discretion of the Court, to be kept in penal servitude for life or for any term not less than three years, or to be imprisoned for any term not exceeding two years with or without hard labour, and with or without solitary confinement.

59. Whosoever shall unlawfully supply or procure any poison or other noxious thing, or any instrument or thing whatsoever knowing that the same is intended to be unlawfully used or employed with intent to procure the miscarriage of any woman, whether she be or be not with child, shall be guilty of a misdemeanour, and being convicted thereof shall be liable, at the discretion of the Court, to be kept in penal servitude for the term of three years, or to be imprisoned for any term not exceeding two years, with or without hard labour."

The Interpretation of the Law

16. In discussing the interpretation of Section 58 of the Offences Against the Person Act, the *Lancet*, on January 29th, 1927, stated:

"Perhaps if it [the law] were re-enacted again to-day an express proviso would be inserted to exempt from criminal liability the fully qualified practitioner who terminated a pregnancy for the *bona fide* purpose of preserving the mother from special danger to life or health. But, as it stands, the law contains no such saving clause; its language is formidable and uncompromising. How comes it, then, that such operations are ever otherwise than criminal? The answer lies in the word 'unlawfully,' which creates the implication that abortion may be lawful as well as unlawful."

What, then, are the circumstances (if any) in which the artificial termination of pregnancy is not illegal? Lord Riddell gave his view of the correct answer to this question when, in his address to a joint meeting of the Medico-Legal Society and the Section of Obstetrics and Gynaecology of the Royal Society of Medicine on January 21st, 1917, he summarized the law as follows:

"It is contrary to the law to procure or attempt to procure a miscarriage except with the object of saving a mother's life or avoiding serious injury to her health. The essence of the offence is a guilty intent. An honest effort to save the life or health of the mother is not illegal, although the practitioner may commit an error of judgement in performing an operation subsequently regarded by other practitioners as unnecessary. He will not be liable to conviction if he honestly believes that what he does is required to save the mother's life or health. If the mother dies in consequence of an illegal abortion, the person performing it may be liable for murder or manslaughter, but these offences cannot be committed in respect of a child in its mother's womb, as the child is not *in rerum natura*. If, however, the child is born alive and subsequently dies, owing to injuries received *en ventre sa mere*, the offender may be convicted of murder or manslaughter."

Consequences of the Vagueness of the Law

17. It has been suggested that there need be no uncertainty in the mind of the medical practitioner as to his freedom to induce abortion, since the law is in fact adaptable in practice, although not in theory, to changes in social thought. To this argument it may be replied that it is unfair to place upon the doctor the responsibility of interpreting public opinion on such matters. Further, that doctors do differ widely in their views and in their practice there is no doubt. The case of pregnancy following rape below the age of consent

may be taken as an example. The law would seem to imply that a girl aged 13, who is the victim of rape and whose pelvis is too small for safe delivery, should be carried on to full term for delivery by Caesarean section. Is this in accordance with the wish of the community? It is certain that in such a case, quite apart from their religious views, some doctors would refuse to induce abortion, while others would have no hesitation in performing the operation. A similar difference of opinion exists—to take another example—with regard to the legality of inducing abortion for eugenic reasons. Of the leading physicians who submitted memoranda to the committee one apparently regards it as beyond dispute that the pregnancy of a woman of haemophilic stock should be terminated, while another is content to express a " pious hope " that a time will come when abortion may legally be performed to prevent the birth of defective offspring.

18. As bearing on this aspect of the law in relation to abortion the Committee would direct attention to the terms of the Infant Life (Preservation) Act, 1929, Section 1 of which reads as follows:

> 1. (1) Subject as hereinafter in this subsection provided, any person who, with intent to destroy the life of a child capable of being born alive, by any wilful act causes a child to die before it has an existence independent of its mother, shall be guilty of felony, to wit, of child destruction, and shall be liable on conviction thereof on indictment to penal servitude for life.
>
> Provided that no person shall be found guilty of an offence under this section unless it is proved that the act which caused the death of the child was not done in good faith for the purpose only of preserving the life of the mother.
>
> (2) For the purposes of this Act, evidence that a woman had at any material time been pregnant for a period of twenty-eight weeks or more shall be *prima facie* proof that she was at that time pregnant of a child capable of being born alive.

It is herein specifically implied that death of a *viable* child resulting from interference with a pregnancy carried out in good faith for the preservation of the life of the mother is not an offence against the law. It may be urged with considerable justification that by comparison with this Act the law relating to abortion is inconsistent in the uncompromising nature of its language, especially having regard to the fact that the interference with the pregnancy is here necessarily concerned with the death of a *non-viable* child.

19. Quite apart from the wider questions discussed in paragraph 17, it is often urged that the vagueness of the present law allows of a wide latitude of interpretation and that this may lead to very unfortunate consequences. It is stated, at one extreme, that the law is regarded as justifying abortion on the basis of the mental anxiety, sleeplessness, etc., which accompany an unwanted pregnancy, whilst, at the other extreme, it is contended that the doctor may by his reading of the law allow the patient's health to be seriously prejudiced in the absence of overwhelming evidence that the continuance of the pregnancy is certain to cause death. The committee considers that such statements are by no means without foundation. True, it is now generally believed that the termination of pregnancy in the early months is permitted by law where this is carried out with the object of safeguarding the mother's life or health, and that the doctor who performs the operation in the honest belief that these indications exist is free from the risk of conviction. Nevertheless, in its present uncompromising form, the law must be regarded as containing elements which in certain circumstances may leave the position of the doctor exposed to risks of suspicion and professional damage. It should be recognized clearly that under prevailing conditions it is not conviction alone that is dreaded ; indictment of itself, however unjustifiable, may as the result of its concurrent publicity severely damage the professional reputation of a medical man. It has been stated on grounds that the committee believes to be well founded that in the present state of the law practitioners may demur to perform therapeutic abortion, with a consequent risk of sacrifice of the health or life of the patients under their care.

Desirability of Revision of the Law

20. Within recent years there has been considerable agitation in favour of a revision of the law of abortion. With many aspects of this movement the committee is not concerned. It has, however, been represented on many sides, both by the profession and by the public, that there is need for an investigation of the whole question with the object of clarifying the position of the doctor in regard to the law. With this view the committee is in agreement. While it is manifestly impossible to provide exact indications for the induction of abortion, the committee considers it most desirable that the law should at least contain an explicit statement of the principles which should govern the lawful artificial termination of pregnancy.

21. Such a rewording of the law, however, would not in itself remove all the existing difficulties. For the opportunity for difference of opinion in regard to the urgency of the medical indications may expose an honourable practitioner to the risk of his judgement being publicly impugned even where he is protected against the major risk of criminal intent. It is important that the practice of abortion should be so regularized that doctors can be completely safeguarded against risk where their treatment is determined by entirely reputable decisions. The committee thinks that careful consideration should be given to the question as to how far this object can be accomplished by insisting that abortion should be carried out only after the approval of two practitioners has been obtained. To remove any question of collusion, it might with advantage be required that one of the approving doctors should have some recognized status on the analogy of the " approval " given by the Board of Control under the Mental Treatment Act, 1930. This the committee believes to be a proposal of very great importance, the acceptance of which would be one of the greatest boons that could possibly be conferred on the profession in regard to this whole matter.

Some recent changes in the law relating to abortion in other countries are described in Sub-Appendix I.

IV. THE INDICATIONS FOR THERAPEUTIC ABORTION

22. The arbitrary nature of the indications for therapeutic abortion renders decisions on this question amongst the most difficult and, at the same time, the most responsible which the doctor is called upon to make in his practice. In the preceding paragraph statutory means have been suggested by which the interests of both doctor and patient might be safeguarded. The committee believes that a further means towards the same end would be attained if indications which at present are often arbitrary and vague were replaced by standards of a more uniform nature and possessing the advantage of a reasonable measure of general agreement.

23. The committee has carefully considered how far such an object can be realized, and has in the following pages attempted to formulate in a more or less comprehensive manner under the various systems the medical indications for the artificial termination of pregnancy. It would at the outset make it clear that, in the present state of medical opinion, the statement must be regarded as tentative, and that it is merely advanced as a basis for further discussion. In formulating its views the committee has obtained the assistance of authoritative exponents of the individual questions dealt with.

A. Cardiovascular Conditions

24. In women of child-bearing age at least 90 per cent. of organic heart disease is of the rheumatic type. Once established such disease tends to run a progressive course, frequently ending in death from congestive heart failure before the age of 40. Therefore, while it is possible to assess with a considerable degree of assurance the immediate risk of pregnancy and labour proving fatal, it is

more difficult to gauge the remote risk of pregnancy and labour producing an aggravation of the cardiac disability which will shorten life. It is not easy to apportion the blame for aggravation between the strain incidental to pregnancy, the normal downward tendency of the disease, and the extra burden imposed by an additional child on a mother whose activities are already limited by her damaged heart.

25. The great majority of pregnant women suffering from heart disease, given adequate care and supervision, are able to go to term and be delivered, either naturally or by Caesarean section. In a consecutive series of 300 cases there were only seventeen in which therapeutic abortion was performed, and only seventeen in which death occurred either before or shortly after delivery (including two cases in which death followed therapeutic abortion). In only eight of the 300 cases was death attributable solely to the cardiac condition.

26. The following are the main conditions in which the question of inducing abortion ought nevertheless to be considered:

Congestive Heart Failure.—(*a*) A *previous attack* of congestive heart failure is a certain indication for therapeutic abortion. No woman who has suffered from this condition, whether during a previous pregnancy or not, should have another child.

(*b*) Congestive heart failure *during the first three months* is not common, and when it does occur thus early it is probably not directly related to the pregnancy. Nevertheless it is desirable in such cases that the uterus should be emptied, since an added load on the circulation can be anticipated as time goes on, and the heart failure of itself will tend to grow worse. However, to operate in the presence of congestive heart failure without adequate preparation is literally a fatal mistake; but after suitable pre-operative treatment abortion may be induced without undue risk.

(*c*) Pregnancy should be terminated before the end of the third month in those cases in which it is probable that congestive heart failure will appear *before the fifth or sixth month*. During the first three months it is usually possible to judge fairly accurately whether this condition will occur and when it may be expected; and the probable time of its appearance is the most important factor in determining whether the uterus should be emptied. Those women who sleep badly, complain of puffiness of the feet and ankles, and are made breathless on slight exertion are liable to show signs of congestive heart failure by the time the sixth month is reached. In such cases abortion should be performed as early as possible after adequate preparation. The onset of the condition after the sixth month is less dangerous, and usually in these cases the reserve power of the heart can be so restored as to permit of the successful delivery of a living child.

The series of 300 cases mentioned above included twenty-one in which signs of congestive heart failure were present when the patients first came under observation. Six of these patients died before or soon after confinement, five are known to have died within four years after confinement, and four others to have been detrimentally affected. These figures indicate the extreme gravity of established congestive heart failure in the pregnant woman.

Auricular Fibrillation.—A woman showing auricular fibrillation in the early months of pregnancy is a thoroughly bad risk, as she is liable to develop serious congestive heart failure. The pregnancy of such a woman should be allowed to continue only in exceptional circumstances. Auricular extrasystoles are commonly the precursors of auricular fibrillation, and should be regarded seriously, especially when the myocardial reserve is already low.

Repeated Haemoptyses.—Repeated small haemoptyses occur occasionally in subjects of mitral stenosis without there being at the time any evidence of congestive heart failure. Occurring in the early months, this is a danger signal which demands immediate attention. The earlier it is observed the more desirable is the termination of the pregnancy.

Paroxysmal Tachycardia.—This condition is uncommon in pregnancy but can of itself be an indication for abortion. Each case must be judged on its merits, particularly in regard to the response to treatment and the functional efficiency of the heart in the intervals between the attacks.

Complete heart-block is not an indication for termination of pregnancy if the reserve power of the heart is good.

Other Conditions.—Other conditions in which therapeutic abortion may be advisable include the following:

(*a*) Where, in a case of mitral stenosis, there is clear evidence of antecedent embolism, cerebral or pulmonary, whether in association with a previous pregnancy, delivery, or puerperium, or occurring apart from pregnancy.

(*b*) Where, in a middle-aged woman, more especially if she is a primigravida, there is clear clinical evidence of myocardial degeneration—enlarged heart, and/or aneurysm, and/or angina on effort.

(*c*) Where a woman has congenital morbus cordis, with much cyanosis and poor tolerance on effort, and where even early pregnancy definitely enhances her disability.

(*d*) Where a young woman, in the early weeks of her pregnancy, is found to have arterial disease with persistent high blood pressure (150 or over) and definitely enlarged heart, since cerebral haemorrhage and/or heart failure and/or sudden death are likely to occur if pregnancy is allowed to continue.

(*e*) Where a woman, in the early weeks of pregnancy, is found to be suffering from progressive bacterial endocarditis. This is generally a fatal disease, but certain unusual cases may be considered as suitable for the induction of abortion when the condition is discovered during the early months.

B. Renal Conditions

27. *Chronic Nephritis.*—There is no doubt as to the ill effects of pregnancy on the kidneys of patients with nephritis. Exacerbation of the disease in such patients is the rule, and reappearance of symptoms in patients with albuminuria, but in whom other symptoms are absent, is a common event. When to this known damaging influence on the kidney of the mother is added the liability to death of the foetus, the desirability of therapeutic abortion in patients with chronic nephritis can hardly be questioned.

Previous Eclampsia or Pre-eclampsia.—Where there is a history of eclampsia or pre-eclampsia in a previous pregnancy the recurrence of similar symptoms at an early stage of a subsequent pregnancy may necessitate the induction of abortion.

Pyelitis.—Therapeutic abortion may be advisable in certain severe cases of acute and subacute pyelitis.

Tuberculosis.—Therapeutic abortion may be advisable where there is tuberculosis of the kidney, with clinical evidence of pyelitis and diminished renal function.

C. Pulmonary Conditions

28. *Tuberculosis.*—The problem of therapeutic abortion in chest conditions is largely confined to cases of pulmonary tuberculosis. The sequence of pregnancy, parturition, and lactation may exert an unfavourable influence on the course of this disease at all stages. During the actual course of the pregnancy there may be some temporary amelioration of the symptoms, or even an apparent quiescence, but this is usually illusory. After parturition, in spite of special precautions and the prohibiting of lactation, there is as a rule a rapid and marked increase in activity, often of acute character. It not infrequently happens that the disease first declares itself after the first pregnancy, and the course is then often acute and rapidly progressive.

When pregnancy occurs in a woman suffering from *active* tuberculosis the question of therapeutic abortion should be considered in the early months. There is a general consensus of opinion among both obstetricians and physicians that if intervention occurs after the third or the early part of the fourth month the effects on the disease are as marked as if the pregnancy had been allowed to proceed to term. The decision should therefore be made as early as possible, so that if abortion is decided upon it may be induced before the third month.

When a patient with *acute, rapidly spreading disease* is seen, even in the early months of pregnancy, as a

general rule induction of abortion is of little use, as the effects are likely to be unfavourable and the chances of prolonging life are small. Each such case must, however, be judged on its own special features.

If, in the case of a pregnant woman seen in the early months, there is a history of antecedent active tuberculous disease of the lungs or pleurae, or if there is a marked family history of tuberculosis, especially in a primigravida, it should be a routine procedure to carry out a thorough investigation to exclude the presence of active or *recently quiescent* lesions. If definite indications of recent activity are apparent, and especially if laryngeal or intestinal lesions are present, therapeutic abortion should be advised. If in a case of *arrested disease* there have been no active symptoms for three years and the *x*-ray examination shows healed fibroid lesions without cavitation, localized to one or two lobes, and if the patient appears healthy in other respects, the pregnancy should not be terminated. Even in cases where the disease has been more extensive, but where arrest has been stable for some years, the pregnancy may be allowed to proceed, especially if the parents are anxious to have a child, but the risks should be clearly explained to the patient and her relatives.

Other Conditions.—Certain other severe non-tuberculous conditions may have to be considered in relation to therapeutic abortion.

In bronchiectasis the likelihood of septic complications outweighs any possible advantage of abortion.

D. Blood Conditions

29. In certain severe and intractable diseases of the blood, pregnancy may be exceedingly dangerous to the mother and therapeutic abortion may have to be considered ; as, for example, in Leukaemia, Hodgkin's disease, Splenic Anaemia, Aplastic Anaemia, Agranulocytosis, Essential Thrombocytopenia, and refractory forms of Pernicious Anaemia.

E. Gynaecological Conditions

30. Cancer of the cervix is the chief gynaecological indication for therapeutic abortion. If the growth is not beyond reasonable hope of cure the case should be treated by radical operation or by radiation therapy subsequent to therapeutic abortion. If the disease is too far advanced to allow of such therapeutic measures, the pregnancy should not be disturbed.

F. Organic Nervous Conditions

31. Certain severe and refractory cases of chorea gravidarum would seem to be the only organic nervous condition which is improved by therapeutic abortion.

G. Mental Conditions

32. *Psychoneuroses.*—When considering these conditions it is essential to guard against the tendency to use the alleged presence of nervous symptoms as an excuse for terminating an unwanted pregnancy. The first necessity is to make certain that a definite psychoneurosis exists. Even when this is certain abortion is seldom indicated. There are, however, rare cases in which the pregnancy may be considered of psychological importance as a precipitating or aggravating factor, and in which cure is thought to be unlikely if the pregnancy is allowed to continue.

33. *Threatened Suicide.*—There are certain cases in which the risk of suicide is advanced as a reason for therapeutic abortion. In the majority of these abortion is not indicated, but the decision as to this point depends upon the accurate diagnosis and assessment of the merits of each individual case, which can be determined only by a mental expert.

34. *Psychoses.*—Pregnancy occurring in a woman with an established psychosis is unlikely to influence materially the course of the disease. If, however, the pregnancy is thought to be a causal factor, or if it occurs during a remission, abortion may well be justified to prevent aggravation or relapse. In other cases abortion may be deemed advisable, in order to preserve life or to prevent the possible onset of mental disorder.

(*a*) *Manic-depressive Psychosis.*—When this psychosis occurs during pregnancy the patient usually recovers before or after parturition, and there is no proof that abortion shortens the attack. In some cases of depression, however, the psychosis may be held to be definitely due to anxieties and conflicts associated with the pregnancy. In these cases suicide is a distinct danger, and justification for abortion is probably commoner in this class of case than in any other. If it is to be done it should be carried out as soon as possible, as the more established the psychosis is allowed to become the less certain is abortion to cut it short, and the greater becomes the risk of the abortion acting as a psychic trauma with aggravation rather than alleviation of the mental condition.

(*b*) *Schizophrenia.*—When the onset of this condition takes place during pregnancy abortion may be considered justifiable. While there is little clinical evidence to show that abortion benefits these patients, the condition is so serious that it may be desirable to give the patient the benefit of the doubt. If there is intervention it is particularly desirable that this should take place as early as possible, before the psychosis is fully established.

(*c*) *Organic Psychoses.*—Clinical evidence is against abortion in G.P.I. and chronic epidemic encephalitis. On the other hand, abortion appears justifiable in certain psychoses associated with epilepsy—for example, if the fits are becoming much more frequent or the mental state is deteriorating. Status epilepticus in pregnancy is very rare, but when it does occur abortion appears to be indicated.

(*d*) *Previous Insanity.*—When the patient has previously suffered from a psychosis it is not easy to judge whether abortion may be advisable as a prophylactic measure. If the former attack or, still more important, attacks were associated with pregnancy, abortion might be justified. It must be appreciated, however, that if only one previous pregnancy has been accompanied by a mental breakdown the chances are that the present pregnancy will not be so accompanied, and that, even if it were, recovery will again take place. It must also be borne in mind that abortion would not be a sure preventative. In the case of *puerperal or lactational insanity* there is reason to believe that the termination of pregnancy is desirable if the patient has suffered on two or more previous occasions, or if her mother has suffered from this condition and she herself has so suffered on one previous occasion.

H. Miscellaneous Conditions

35. *Diabetes.*—While it occasionally appears that pregnancy is responsible for a deterioration in the condition of a diabetic patient, the great majority of such patients may be allowed to go on to term without fear of serious damage resulting.

Exophthalmic Goitre.—Therapeutic abortion should, as a general rule, be avoided in the mild cases of exophthalmic goitre, inasmuch as improvement is often associated with pregnancy, but in severe cases associated with toxic myocarditis abortion may be indicated.

Diseases Arising Out of Pregnancy.—These include toxic vomiting and toxic jaundice. Such conditions occasionally call for therapeutic abortion.

Neoplasms.—Malignant tumours generally do not constitute an indication for therapeutic abortion, with the exception of certain cases of carcinoma of the cervix (see para. 30).

Repeated Dangerous Labours.—The doctor is often consulted during early pregnancy with a view to induction of abortion because the patient's previous labours have caused grave anxiety by reason of mechanical difficulty, inertia lasting several days with subsequent risks of sepsis, adherent placenta causing haemorrhage and sepsis, and other conditions. Many of these women are suffering in addition from *mental trauma,* following upon repeated ordeals of pain and danger, which causes fear and depression. It is a fact that the mortality of childbearing rises steadily after the fourth pregnancy, and therefore where previous labours have been dangerous the statistical risk will increase with successive labours. In the consideration of these patients it is important to decide whether previous difficulties have been due to faulty

mechanics such as pelvic contraction and malpresentation, or due to disturbed function, illustrated by severe inertia, adherent placenta, and haemorrhage. The former group can generally be treated safely by Caesarean section, but in the latter group there may still be danger even if Caesarean section be performed. Further, these women are often in a state of depressed health and vitality, due to their previous difficult labours, and for them Caesarean section is not as safe as for the normal healthy pregnant woman. Each case in this group must be considered on its merits. Most doctors will agree that where the dangers or difficulties are such that they are liable to be repeated, possibly with greater intensity, it is correct to perform abortion.

Rapidly Repeated Pregnancies which cause Depressed Health.—It is well known that there are women who have had many pregnancies at short intervals, which have reduced them to a condition of physical and mental debility. If, after consultation and examination, it is certain that their physical and mental health is being affected and there is reasonable certainty of chronic invalidism resulting from the current confinement, then induction of abortion should be seriously considered.

Pregnancy following Rape below the Age of Consent.—It is well known that girls under 16 years of age usually pass through labour without difficulty or danger. A valid medical reason based upon physical considerations can seldom be advanced on account of age alone, but whether the severe *mental* injury, caused by an experience so dreadful as childbirth at a tender age, should not be accounted an even greater indication than physical danger is a point to be considered very seriously.

I. Hereditary Conditions

36. Whilst under existing conditions reasons based on eugenic considerations are generally regarded by medical men as falling outside the scope of therapeutic abortion, the committee believes that there are certain cases of this class which constitute justifiable indications. It is of the opinion that therapeutic abortion should be considered when, in the light of modern medical knowledge, there is reasonable certainty that serious disease will be transmitted to the child. The following are conditions in which such indications may occur.

Mental Deficiency.—The offspring of two mental defectives will almost certainly be mentally defective, while the offspring of a mental defective mated with a normal person may be defective or psychopathic and will probably transmit to one or more members of the next generation either mental deficiency or some psychopathic trend (such as a tendency to alcoholism, epilepsy, insanity, congenital psychasthenia, or drug addiction).

The following are conditions in which abortion might be thought allowable:

(*a*) If both parents are certified mental defectives.

(*b*) If the father and one child are certified mental defectives.

(*c*) If the father is psychopathic and one child is a certified mental defective.

(*d*) If two certified mentally defective children have already been born (even when neither parent is apparently defective or psychopathic).

Other Hereditary Conditions.—Hereditary conditions which might be thought to justify the termination of pregnancy in the interests of eugenics include certain blood conditions, hereditary deaf-mutism, and hereditary blindness.

V. THE MEDICAL ASPECTS OF THE PROBLEM OF CRIMINAL ABORTION

Prevalence and Danger of Criminal Abortion

37. In previous pages reference has been made to the gravity of the problem of criminal abortion from the standpoint of public health. In modern civilized communities the deaths from abortion comprise a large proportion of the total maternal mortality rate. The Final Report of the Committee on Maternal Mortality and Morbidity (1932) indicated that in England and Wales 13.4 per cent. of maternal deaths were caused by abortion. This figure, although high, is considerably lower than the rates found to obtain in some other countries—for example, Germany, Holland, and Sweden.

38. Attention has already been drawn to the fact that there is no means of assessing accurately the extent of the practice of criminal abortion. It is notorious that, where there has been criminal interference, expert advice may be called only in the event of untoward symptoms developing. Further, in many instances where there is a strong suspicion of unlawful interference it is extremely difficult to obtain evidence to warrant the case being so classified.

39. The statistics of deaths from criminal abortion give no true indication of the frequency of the practice, since it is certain that for every fatality there is a large number of women who escape with their lives. In the absence of definite statistical evidence, the committee nevertheless considers that the opinion universally held by the medical profession that interference with pregnancy for reasons other than medical is widely prevalent among all classes of society must be accepted as truly indicative of the general situation.

40. The dominating cause of post-abortion mortality is sepsis. In England and Wales during the years 1930–2 sepsis accounted for 72.5 per cent. of the abortion deaths. The reports on maternal mortality in New York and Philadelphia give percentage rates of 73.4 and 86.2 respectively.

41. There is strong evidence for the view that the great majority of the deaths from abortion follow illegal interference. The high degree to which sepsis contributes to the mortality confirms this view. In the absence, however, of any reliable data regarding the total incidence of abortion in the community and, among those cases that are known, of the relative proportions of the spontaneous and the criminal types, an accurate estimate of the extent of the danger to the public health inherent in the illegal interference with pregnancy is difficult to establish. It has generally been considered that it is legitimate to assume that the bulk of the sepsis deaths follow instrumental interference, and from this it has been concluded that the overwhelming proportion of the abortion death rate is caused in this way. This view, in addition, has behind it the clinical experience of all who have directed special attention to these questions. At the same time there has been singularly little evidence of a convincing nature published in this country and based upon an adequate series of figures. Recently Parish[1] has studied 1,000 cases of abortion treated as in-patients in St. Giles's Hospital, Camberwell, during the years 1930 to 1934. In this total 485 women admitted illegal interference, 111 by means of drugs only and 374 by means of instruments (syringe 108, syringe and drugs 170, catheter 7, slippery elm bark 16, knitting needle 5, abortionist 9). In 246 there was no evidence of interference, and in this group pathological factors which were present were regarded as providing the explanation. In the remaining 269 the aetiology was unknown. It is significant that in the group of 374 due to admitted instrumentation the febrile rate was 88.2 per cent. and the death rate 3.7 per cent., whilst in the group of 246 due to pathological conditions and with no history of interference the febrile rate was only 5.7 per cent. and the mortality rate *nil*. This record tends to confirm the commonly accepted view that illegal interference contributes in an overwhelming degree to the mortality from abortion. The figures just quoted refer to hospital cases, and, therefore, to clinical material of a selected character from which it would be unwise to generalize in regard to the conditions obtaining in the country as a whole. Probably it may safely be assumed that the secrecy surrounding the illicit practice implies that for this type hospital figures are more selectively overweighted with the serious cases than obtains for spontaneous abortion. Nevertheless, the figures of Parish do tend in a convincing manner to emphasize that the criminal operation plays a dominating part in the death rate from abortion.

[1] Parish, T. N.: "A Thousand Cases of Abortion," *Journ. Obstet. and Gynaecol. British Empire*, December, 1935, p. 1107.

42. It is unnecessary to state that the high degree in which sepsis contributes to the death rate is to be explained by the fact that the interference is, in general, carried out by persons who are unskilled, and often dirty in their person and careless in their methods. The committee obtained evidence from medical men with considerable experience in the investigation of the medico-legal circumstances associated with such deaths which revealed the appalling conditions under which abortionists often undertake their work. For example, in a case in which a woman was found with a piece of catheter in the cervix the abortionist charged with the crime was discovered to possess numerous similar fragments which she apparently used over and over again. It was proved that she had been responsible for a large number of cases of septic abortion.

Sociological Factors

43. Among the factors that constitute the sociological background of criminal abortion there are two that stand out prominently. There is, first, the relatively greater frequency of the practice in the towns as compared with the rural districts. The higher urban incidence is a feature of all modern communities. The Registrar-General states that in England and Wales during 1930 the percentage of the total maternal mortality due to sepsis caused by abortion was 35.1 for London, 24.6 for county boroughs, and 19 for rural districts. In some Continental towns the rate is higher. Thus, in Berlin, during the years 1922–4, the percentage of the maternal sepsis death rate due to abortion was 81.2, whilst in Stockholm it has been computed that during the five-year period 1926–30 post-abortion sepsis accounted for more than 50 per cent. of the total maternal death rate.

44. The second finding of sociological importance in respect of criminal abortion is its relatively high frequency amongst married women. This fact has been repeatedly emphasized in the evidence which the committee has had presented to it. Parish, in his investigation of 485 abortions in which illegal methods were admitted, found only forty-one—that is, 8.2 per cent.—in single women. In further cases the illegal procedure had been carried out by widows or women known to be living apart from their husbands. "In seventy-eight out of 100 patients who were questioned fully, poverty appeared to be the determining factor, in nine cases obstetric fears due to previous difficult confinements were given as the reason for procuring abortion, and in the remaining thirteen cases the excuses given were considered to be trivial."

45. In any attempt to assess the extent of the danger to the health of the community caused by criminal abortion it is important to remember that, in addition to the toll which it exacts each year in the form of deaths from sepsis and other causes, there is a much greater number of women whose health is injuriously affected, often permanently, by the damage which they then sustain. It is known that many of the gynaecological beds of our hospitals are continuously occupied by women with chronic pelvic inflammation which is traceable to this cause.

Is Criminal Abortion Increasing?

46. The committee has been unable to obtain unequivocal evidence to support the often-expressed view that illegal abortion is increasing. The Registrar-General's figures show that the total deaths in England and Wales attributed to or associated with abortion during the six years from 1928 to 1933 were as follows: 488 (244), 605 (238), 568 (300), 503 (229), 538 (262), 560 (257). These and the number of deaths during the corresponding years from post-abortion sepsis, which are shown in brackets, reveal no appreciable trend during this period. At the same time, as has previously been indicated, the Ministry of Health figures, which are based upon the reports of maternal deaths received through the local health authorities, show that the percentage of the maternal mortality attributable to abortion has increased from 10.5 in 1930 to 16 in 1933.

Preventive Measures

47. The committee believes that the placing of therapeutic abortion on a sound basis in respect of the law would tend to some extent to reduce the incidence of unlawful abortion in so far as it would remove the occasions for the illicit practice being resorted to by women in whom there may be adequate medical grounds, but who, under present conditions, find it difficult to obtain the necessary medical sanction. The committee is convinced that the adoption of some such method as it has advanced to ensure greater protection than exists at present of the doctor who carries out therapeutic abortion with honourable intent would, by increasing the *bona fide* practice, tend to a corresponding lowering of the unlawful procedure.

48. The committee has carefully considered how far *notification of abortion*, which has been recommended in influential quarters, would be likely to assist in controlling the present position. It is satisfied that, apart from providing data regarding the incidence of the therapeutic operation, this procedure could not be expected to furnish any reliable information regarding the incidence and the risk associated with abortion in general. The considerations which explain the difficulty in obtaining accurate clinical data, to which reference has already been made, apply with equal or even greater force to notification. It is certain that strenuous resistance would be offered by the patients and their relatives to such inquiries as might be made by the medical officer of health, and the effect of the plan might well be to increase the reluctance of the patients to consult a registered medical practitioner.

49. It would be inappropriate for the committee to express an opinion in regard to such matters as the social, the economic, and the ethical factors which are intimately bound up with the widespread practice of unlawful abortion. These constitute aspects of the question with which the doctor, in his confidential relationship with the public, is often brought into immediate contact, and the influence and meaning of which he is naturally peculiarly able to appreciate. At the same time, the validity of the claim that such considerations should be advanced, as they have been advanced in influential quarters, in favour of the legalization of abortion for other than medical reasons, is not one on which the profession in its corporate capacity can be expected to express an opinion. It is, of course, impossible to divorce these larger questions, on which the community as a whole can alone adjudicate, from one consideration which is of profound significance to the public health, and which indeed constitutes a stable argument in support of the propaganda to which reference has just been made. This is that the legalizing of abortion, under certain controlled conditions, for social and economic reasons, would, by regularizing the practice, rescue the public from the risk to life and health implied in an illicit procedure in the hands of unskilled persons.

50. The example of Soviet Russia is of special interest in this connexion. It is claimed that the placing of abortion in skilled hands has reduced the risks to a minimal figure. Thus, in 1926 artificial abortion in Moscow was carried out on 29,306 women with no mortality, while in women admitted to hospital after secret abortion the mortality was 1.2 per cent. In a total of 175,000 operations performed in Moscow there were nine deaths—that is, 1 in 19,000.

51. The committee is unequivocally of opinion that, within the range of those medical conditions which render pregnancy dangerous to life and health, the avoidance of pregnancy is to be encouraged as a procedure of double value in that it protects the woman against the risks to which pregnancy exposes her, and at the same time it eliminates the occasion for therapeutic abortion and the temptation to adopt unlawful methods.

Abortion and Professional Secrecy

52. It sometimes happens that a doctor, on being called in to attend a woman on whom an illegal operation has been performed, is faced with the problem of whether it is his duty to give information to the police. In 1915

the British Medical Association, after special consideration of the matter, decided that the conduct of the doctor in this particular situation should be governed by the following resolutions:

(i) that a medical practitioner should not under any circumstances disclose voluntarily, without the patient's consent, information which he has obtained from that patient in the exercise of his professional duties ;

(ii) the Association is advised that the State has no right to claim that an obligation rests upon a medical practitioner to disclose voluntarily information which he has obtained in the exercise of his professional duties.

It is obviously desirable, however, that the medical profession should assist in every legitimate way in combating the evil of criminal abortion. The committee therefore considers that the doctor, on ascertaining that a patient has undergone an illegal operation at the hands of an abortionist, should endeavour to obtain the consent of the patient to his reporting the matter to the police authorities.

VI. CONCLUSIONS AND RECOMMENDATIONS

53. The following are the main conclusions and recommendations of the committee.

The Law Concerning Therapeutic Abortion

1. The Offences Against the Person Act of 1861 prohibits the *unlawful* induction of abortion. The wording of the Act may be thought to imply that abortion may be lawful as well as unlawful, but in the law as it stands no specific authority is given for terminating pregnancy, except under the conditions already discussed in paragraph 18. The Committee considers it to be most desirable that this very unsatisfactory situation should be remedied by revision of the law.

II. While professional opinion appears to differ on the question of the desirability of legalizing abortion to prevent the birth of a mentally or physically defective child, it is generally believed that the operation should be permissible when the indications are that continued pregnancy or labour will endanger the life of the mother or seriously injure her health.

III. Nevertheless there are substantial grounds for believing that, even when such indications are present, the doctor sometimes hesitates to perform the operation through fear, if not of conviction, at least of indictment, with the publicity and the risk of professional damage which this entails.

IV. Further, since opinions may differ as to whether the patient's condition is such as to warrant therapeutic abortion, the doctor runs the additional risk of his judgement being publicly impugned in the event of the operation being followed by the death of the patient. There is reason to believe that this consideration acts as a deterrent, with consequent danger, in some cases, to the life or health of the patient.

V. The committee therefore strongly recommends not only the clarification of the legal position, but also the institution of some system of authorization of abortion in the individual case. It suggests that the doctor contemplating therapeutic abortion should be obliged to obtain the sanction of a professional colleague of recognized status, on the analogy of "approved" practitioners under the Mental Treatment Act.

The Indications for Therapeutic Abortion

VI. The committee presents suggestions as to the conditions in which the advisability of terminating pregnancy for medical reasons may call for consideration. The committee recognizes that it is impossible to lay down hard-and-fast rules, and that each case must be judged on its merits.

VII. Whilst under existing conditions reasons based on eugenic considerations are generally regarded by medical men as falling outside the scope of therapeutic abortion, the committee believes that there are certain cases of this class which constitute justifiable indications. It is of the opinion that abortion should be considered when, in the light of modern medical knowledge, there is reasonable certainty that serious disease will be transmitted to the child.

Secret Abortion

VIII. The frequency of secret abortion cannot be exactly ascertained, since the very secrecy of the practice makes statistical assessment of its prevalence impossible. That the induction of abortion, usually by unskilled persons, for reasons other than medical, is very common in all ranks of society there can, however, be no reasonable doubt.

IX. The committee considers it to be of the greatest importance that the grave dangers to life and health entailed by the practice of secret abortion should be represented to the public and to those concerned with the public welfare.

X. The committee believes that the measures which it has suggested for the protection of the practitioner would, by increasing the *bona fide* practice, result in diminution of the frequency of the secret procedure.

XI. While the committee has no doubt that the legalization of abortion for social and economic reasons would go far to solve the problem of the secret operation, it realizes that this is a matter for consideration by the community as a whole, and not by the medical profession alone.

XII. With a view to combating the evil of secret abortion the committee recommends that the practitioner, on ascertaining that a patient has undergone an illegal operation at the hands of an abortionist, should endeavour to obtain the consent of the patient to his reporting the matter to the police authorities.

XIII. Although the committee has drawn attention to conditions in which the termination of pregnancy is indicated, it believes that in such cases the avoidance of pregnancy is the more rational plan and one to be encouraged as a procedure of double value in that it protects the woman against the risks to which pregnancy exposes her, and at the same time it eliminates the occasion for therapeutic abortion and the temptation to adopt unlawful methods.

SUB-APPENDIX I

THE LAW RELATING TO ABORTION IN FOREIGN COUNTRIES

Artificial abortion is illegal in most foreign countries, including Belgium, France, Switzerland, Austria, Germany, Scandinavia, and the United States. In recent years, however, there has been considerable agitation for reform of the abortion laws, and in a few countries such reform is receiving official consideration or has already been effected. The most notable examples are Russia, Poland, and Czechoslovakia.

Russia

In Tsarist Russia abortion was punished by solitary confinement. The Revolution of October, 1917, abolished the penalties and made abortion free. This measure was ineffectual because the secret abortionists of the past continued their nefarious practices. The Commissariat of Hygiene, on November 18th, 1920, therefore took steps to regulate the practice of abortion by legislation. The following are the most important articles of the statute:

1. Interruption of pregnancy shall be free and permissible in Soviet hospitals.

2. Abortion by unqualified medical practitioners is prohibited.

3. Any midwife guilty of performing an abortion will lose the right to practise her profession and will be tried by Popular Tribunal.

4. A doctor who performs an abortion outside a hospital for the purpose of financial gain shall be subjected to the Popular Tribunal.

The following are included in the medical and social indications for abortion:

1. Pregnancy resulting from rape or assault.
2. Pregnancy of an unmarried girl not of full age.
3. Pregnancy in a mother of a family of at least three children who is earning her own living and would be unable without difficulty to provide for a larger family.
4. Medical indications: tuberculosis, alcoholism in the parents, epilepsy, psychosis (November, 1933).

With rare exceptions abortion is prohibited after the third month, and it cannot be repeated until nine months have elapsed since a previous abortion. A woman desiring the operation must apply to the proper authority, who considers all the circumstances. The procedure is permitted only by duly authorized practitioners and hospitals, and it is claimed that 80 to 85 per cent. of all abortions are now registered. Secret abortion is now rare in towns, but is still relatively prevalent in rural areas.

POLAND

In Poland the law relating to abortion was revised in 1932, and the operation is now permitted in the following circumstances when performed by a qualified physician with the woman's consent:

1. When the woman's life or health is endangered by the pregnancy.
2. When the pregnancy is due to interference with a girl under 15 years of age, abuse of the totally or partially mentally defective, the use of threats or violence to obtain sexual consent, or the misuse of a position of authority or of special circumstances of power or danger.

CZECHOSLOVAKIA

Recently the Government of Czechoslovakia has considered a Bill designed to legalize abortion in the following circumstances when the operation is performed with the woman's consent by an authorized medical practitioner in a public hospital:

1. If the termination of pregnancy is advisable to prevent the risk of the mother's death or of serious injury to her health.
2. If it is proved that conception took place after rape or after the violation of a girl under 16 years of age.
3. If it is proved that the child would be gravely injured mentally or physically.
4. If the woman is mentally ill and her guardian gives his consent to the abortion.
5. If the pregnancy could not be completed, or if the child could not be reared without adversely affecting the nutrition of the mother or other persons under her legitimate care.

It is proposed that, when it is not possible to perform an abortion in a public hospital, it will be sufficient for the operating physician to obtain the consent of a colleague besides that of the woman herself. This Bill, however, has not yet been passed into law.

SUB-APPENDIX II

The committee wishes to express its gratitude for the valuable help received from the contributions of the following, who attended meetings of the committee to give evidence and/or submitted written memoranda:

Mr. A. S. Blundell Bankhart; Sir Comyns Berkeley; Dr. C. P. Blacker; Dr. J. Crighton Bramwell; Dr. M. Forrester Brown; Miss F. W. Stella Browne; Professor A. W. M. Ellis; Dr. A. R. Gilchrist; Dr. C. M. Hinds Howell; Dr. J. S. Manson; Dr. P. K. McCowan; Dr. G. C. Mort; Dr. Sydney A. Owen; Dr. W. B. Purchase; Sir Bernard Spilsbury; Dr. L. J. Witts; Dr. R. A. Young.

APPENDIX VIII

REPORT OF COMMITTEE ON MINERS' NYSTAGMUS

Preliminary

The Committee was appointed by the Council on July 23rd, 1935, with the following reference: "To consider and report upon the possibility of securing improved methods of procedure in the diagnosis and certification of miners' nystagmus."

The Committee consisted of the following members:

Sir John H. Parsons, C.B.E., LL.D., F.R.C.S., F.R.S., London (Chairman).
E. Kaye Le Fleming, M.A., M.D., Wimborne (Chairman of Council).
H. S. Souttar, C.B.E., F.R.C.S., F.R.A.C.S., London (Chairman of Representative Body).
N. Bishop Harman, LL.D., F.R.C.S., London (Treasurer).
Herbert Caiger, F.R.C.S., Sheffield.
Millais Culpin, M.D., F.R.C.S., London.
R. G. Gordon, M.D., F.R.C.P.Ed., Bath.
R. Francis Jones, M.A., M.B., B.Ch., Tamworth, Staffs.
T. L. Llewellyn, M.D., B.S., Nottingham.
S. Spence Meighan, M.B., Ch.B., F.R.F.P.S., Glasgow.
H. Campbell Orr, M.B., Ch.B., F.R.F.P.S., Wolverhampton.

The Committee is indebted to J. J. Healy, M.B., Ch.B. (Llanelly) and D. H. Russell, M.C., M.D., F.R.C.S.Ed. (Wakefield) for their assistance in the course of its deliberations. It also desires to thank the large number of medical practitioners—ophthalmic surgeons, certifying surgeons, and general practitioners in mining districts—who rendered valuable assistance by completing a questionary.

The Committee presents its report under five main headings:

I. Introduction.
II. The psychoneurotic aspect of the disease.
III. Certification.
IV. Preventive measures:
  (*a*) Illumination in coal mines.
  (*b*) Preliminary examination of the eyes.
V. Management of certified cases.

I.—INTRODUCTION

1. Miners' nystagmus is an occupational disease of coal miners, of which the characteristic symptom and physical sign is an oscillation of the eyes.

2. Affection of the eyes of colliers has been known for over a hundred years, but miners' nystagmus as such was first described by Decondé in 1861. A historical account of the disease may be found in the First Report of the Miners' Nystagmus Committee of the Medical Research Council, 1922.

3. Throughout its history miners' mystagmus has always been the subject of dispute. At first the dispute was entirely concerned with problems of causation. Diagnosis was based on oscillation chiefly, and caused little difficulty; hence assessment of incapacity was easy. To-day the cause of the disease is generally held to be deficiency

of underground illumination, but the undoubted association of the fundamental disease with psychoneurotic conditions has led to great difficulties, not only in diagnosis and treatment but also in the assessment of incapacity.

4. Until 1907, when miners' nystagmus was included in the schedule of industrial diseases appended to the Workmen's Compensation Act, the industry was able to provide a change of occupation for the few cases reported. From 1908 the number of cases certified rose rapidly,[1] especially after the definition of the disease was altered in 1913. The last available statistics, up to 1934, show that the average yearly number of cases (new and old) of miners' nystagmus in receipt of compensation has been over 10,000 in the last eleven years. The average yearly cost of compensation has been approximatly half a million pounds. There was a decrease, however, in the number of new cases, from 3,066 in 1930 to 1,522 in 1933.

5. In 1923 there were 972,000 underground workers, but this number had fallen to 618,000 in 1933. This great reduction of personnel has been largely brought about by what is called "intensive mining." This is the general introduction of machinery not only for coal cutting but also for conveying the coal on travelling belts. This system of mining calls for an increased tempo of work and the replacement of the older skilled collier by labourers, whose chief function is to lift the coal cut by the machines on to the belts. In 1924 19 per cent. of the coal was got by machinery; in 1933 the percentage was 42, and in the Nottingham area 52 per cent. In March, 1935, when a pit employing 473 men changed over to machine mining, nearly 200 men were discharged, seven of whom were certified as disabled by miners' nystagmus after their suspension. In spite of the discharge of 200 men the output of the pit increased.

6. In the Third Schedule to the Workmen's Compensation Act the description of the disease is now given as follows:

> "The disease known as miners' nystagmus, whether occurring in miners or others, and whether the symptom of oscillation of the eyeballs be present or not."

The admission of cases showing no oscillation has been largely responsible for the prevailing uncertainty and the contradictory pronouncements of medical authorities and referees.

7. In Belgium and Germany the presence of oscillation is necessary before the disease is certified. In Belgium the payment of a subsidy does not extend beyond six months. In America, where compensation is not payable, no cases are reported. In India, where the workmen return at intervals to land work, miners' nystagmus is unknown.

8. There is no doubt that the alteration of the definition has led to the inclusion of cases not suffering from miners' nystagmus—for example, cases of giddiness on stooping in elderly men suffering from high blood pressure.

9. The present dissatisfaction of the miners with the administration of the Workmen's Compensation Act in cases of miners' nystagmus is largely economic and not medical in origin. The coal industry is working under conditions of great difficulty on account of increased competition from abroad, hindrances of the quota, and continual wage disputes; while the shifting of the responsibilities for disabled workmen to insurance companies and mutual indemnity companies leads to a loss of personal touch between manager and workmen. The introduction of intensive mining has displaced a large number of men, especially the skilled collier who is getting on in years. Such men cannot stand the increased tempo, and are forced to give up work. Men discharged as surplus to establishment, especially those over 45, give up hope of obtaining employment elsewhere, and, knowing they have signs of miners' nystagmus, often get certified in self-protection.

10. Industrial fear affects the management as well as the men. Under the stress of modern competition working costs have to be reduced to the minimum, and there is little scope for the sympathetic treatment of disabled workmen. The introduction of labour-saving machinery on the surface has resulted in a further reduction in the work available for partially disabled workmen, and the employment of a nystagmic collier on the surface may only be possible by the discharge of an able-bodied man.

11. Some colliery managers adopt the attitude that once a man has been disabled by miners' nystagmus he should never be allowed to go underground again. Speaking generally, men should not be sent back to work under the identical conditions which produced their disability. Nevertheless, most of the cases of miners' nystagmus recover and, if provided with better illumination, are able to resume their own work. The trouble has been that the men are not allowed to return to work either below ground or on the surface. These men tend to cling to whatever nervous symptoms they may suffer from, and, from being unemployed, become unemployable. From the relatively mild affliction of precompensation days miners' nystagmus has become the dread of all colliers and the despair of insurance companies.

12. It has been shown by many observers that at least 25 per cent. of all workmen employed underground show physical signs of miners' nystagmus. Despite the evident oscillations, many of these men continue at their work without wage-earning loss. What changes this condition into the disabling variety? There is no doubt that acute illness—especially influenza—accidents, and fear of loss of employment help to precipitate an attack; indeed, the onset may be due to the development of an acute anxiety state. This aspect of the disease is discussed in Section II below.

II.—THE PSYCHONEUROTIC ASPECT OF THE DISEASE

13. The following symptoms are most commonly mentioned as being of importance in the diagnosis of disablement from miners' nystagmus: oscillations, dizziness, tremors, blepharospasm, impaired vision, photophobia, headache, tachycardia, and various "nervous" or "neurotic" symptoms.

14. All these, with the exception of oscillations, commonly occur in psychoneurotic syndromes. They are, however, only superficial indications of an underlying condition which is generally a hysterical, anxiety, or obsessional state. The symptoms of the anxiety or obsessional state are commonly concealed by the patient, who may be ashamed of them, and are as a rule elicited only by someone who has an understanding of their significance. There is, for example, a tendency for some practitioners to regard phobias as foolish imaginings, to be treated accordingly, whereas they are often the fundamental disability upon which the other symptoms are excrescences. Obsessional symptoms present still more difficulties to the practitioner, who is seldom aware of their nature or their existence in any specific case.

15. In an examination of thirty-six miners receiving compensation for nystagmus,[1] it was found that at one end of the scale two men showed gross oscillations and complained of no symptoms except subjective movement of objects and resultant giddiness and headache: at the other end of the scale, among men in whom no oscillations could be detected by ordinary methods were two with severe obsessional symptoms which must have been of very long duration. Between these extremes were found men exhibiting a great variety of symptoms such as are found in any collection of nervous patients.

16. A large number of cases now receiving or claiming compensation for miners' nystagmus are really cases of psychoneurosis, and therefore can be understood only when examined from this aspect. The absence of such an understanding will maintain the state of confusion which now exists, a confusion which arose from earlier mistakes that may be very difficult to undo.

17. The point that needs to be emphasized is that the nervous symptoms are not specifically due to the miner's occupation. The only part of his disease that can be directly and invariably attributed to his occupation is

[1] Third Report of the Miners' Nystagmus Committee of the Medical Research Council, 1932, p. 6.

[1] Ibid., p. 16.

the oscillation of the eyes. Apart from this essential factor in miners' nystagmus, any nervous symptom or neurosis he may exhibit presents nothing peculiar to men of his calling, but has the ordinary features of an anxiety or other neurosis due to other causes. To go on indefinitely paying compensation to a miner who has lost his nerve in this manner long after he has ceased to have any oscillations, and to call his disability miners' nystagmus, is a mistake and tends to perpetuate in the minds of sufferers, and of medical men who are asked to certify them, a false conception of the disease. An alteration of the official definition of miners' nystagmus is urgently required.

18. Oscillations of the eyes must be regarded as an essential sign of a disease which bears the name of "nystagmus." Unless oscillations are detected at some stage the patient cannot be said to be suffering from the disease. Cases of true miners' nystagmus must be distinguished from cases showing disabling neurotic symptoms but no oscillations. The whole question of psychoneurosis in industry is an important one, but is outside the reference of the Committee. The differentiation of miners' nystagmus from the general class of psychoneuroses in industry has been held by some physicians to be arbitrary, but the particularity of the sign of nystagmus to the occupation of the miner does mark the disability as peculiar to miners, and therefore, in the opinion of the Committee, the distinction should be maintained.

III.—CERTIFICATION

19. The present method of certification is as follows. Before a miner can make any claim for compensation on account of the disease known as miners' nystagmus he must (unless the employer agrees to dispense with such certificate) obtain from the certifying surgeon for the district in which he is employed, a certificate of disablement on the prescribed form. For this certificate the workman pays the fee of five shillings. If either the employer or the workman is aggrieved by the action of the certifying surgeon in giving or refusing to give a certificate of disablement he may appeal to one of the medical referees appointed under the Act, and his decision is final. In order to decide whether to make such appeal it is customary for the aggrieved party to have the workman examined by their own doctor, who, in cases of miners' nystagmus, will usually be an ophthalmic specialist.

20. Provided that due care is exercised in the selection of certifying surgeons, the Committee is of opinion that the present arrangements for initial certification should not be disturbed. The certifying surgeon should, however, be impressed with the importance of basing his opinion on his own medical examination, using particular care in his assessment of the subjective symptoms described to him by the patient. He should also be instructed to refuse certificates when he is in doubt, or to refer the patient to a higher medical authority. It is recommended that, in the prescribed form of certificate (Form 3) to be completed by a certifying surgeon, the heading

"4. Leading Symptoms of Disease"

should be altered to read:

"4. Physical Signs Found on Examination."

It is further recommended that the form should contain the following instructions to the examiner:

"Cases should not be certified as miners' nystagmus unless definite oscillation of the eyes can be detected.

Certificates should be withheld from men who have been working regularly up to the time of their suspension or dismissal on account of bad trade."

21. There is considerable dissatisfaction with the position of the medical referee. As there is great diversity of opinion on the subject of the capacity for work of men suffering from miners' nystagmus or men recovering from miners' nystagmus, much depends upon the attitude of the individual referee. Thus in one area men may be sent back to work underground even if oscillations are still present, whereas in another area the medical referee may hold that a man is unfit to resume work underground if he has once been certified as suffering from the disease. There are many variations of opinion between these two extremes. In these circumstances considerable dissatisfaction has arisen among the miners, among employers or insurers, and among the medical men associated with the cases. At present the opinion of the medical referee is final, and it has been held in the Appeal Court that if the medical referee certifies a man who is still suffering from oscillation as fit to resume work underground there can be no reversal of that decision.

22. The Committee feels that to place this responsibility on a single individual in such a disease is unfair. It is therefore recommended that the medical referee be replaced by a Medical Board, and that, unless there are questions of law at issue, all cases of dispute should be referred to this Board, and a County Court judge (or a Sheriff's Court in Scotland) should have no power to refuse such reference. References to the Board should be made only when one party feels aggrieved, and the present custom of periodical examination by the employers' medical officer should be continued, agreement by consent being the best method of settling disputes.

23. The Medical Board should consist of two ophthalmic surgeons with experience of the disease and a physician with some knowledge of psychological medicine. The Board might be selected from a panel of medical men set up in each mining district.

24. There should be a statutory obligation on the workman to submit himself for examination, and the findings of the Board should be conclusive and final evidence on the medical aspect of the case.

The Board should:

(i) certify the condition of the workman, including whether the disease was, in fact, contracted during the course of employment, and if so, the date on which the disablement commenced;

(ii) assess his present fitness for work and recommend, where necessary, the kind of employment for which the workman is fit; and

(iii) be given power to declare that a man, having been certified and having recovered sufficiently to resume work underground, should not resume work underground after a second relapse.

The question of susceptibility to another attack of an industrial disease should not arise, as the man can be recertified in that event. Specialist assistance for the Medical Board should be obtainable if required.

25. All parties should be encouraged to feel that the Medical Board is set up to render them assistance and for the purpose of co-operating in efforts towards improvement, not only for the miners but also for the employers.

26. There is a feeling at present amongst medical referees that the remuneration for their services is inadequate. In considering the displacement of medical referees by a Medical Board, therefore, it should be borne in mind that, unless the remuneration of the individual members of the Board is greater than that paid to medical referees, the medical practitioners who are best suited for this class of work will not be attracted to it. The members of the Board should be remunerated on a sessional basis, and should each receive a fee of six guineas for a half-day session or a fee of ten guineas for a session extending to a full day, plus travelling expenses.

IV.—PREVENTIVE MEASURES

(A) Illumination in Coal Mines

27. The importance of adequate lighting is now everywhere realized. In the Third Report of the Miners' Nystagmus Committee of the Medical Research Council (1932) a strong recommendation is made that the illumination of the working area should be 0.25 foot-candle throughout the shift in order to ensure that the critical point at which vision changes from central to peripheral should be passed. The report goes on: "Even if

illumination were raised to 0.1 foot-candle over the immediate working area constantly maintained throughout the shift the incidence of miners' nystagmus would be greatly diminished." The results of investigations published in this report show that with improvement of illumination the incidence of miners' nystagmus diminishes and that men are often able to return to their work when given better lamps.

28. Of late years great improvements in lighting have been carried out, and the Coal Mines Regulations now lay down a standard of efficiency. All new lamps after 1934 and all lamps by the end of 1936 must have a minimum mean horizontal candle-power of 1.5.

29. The essentials of good lighting must be remembered. The lighting should be sufficient, uniform, and free from glare. It is difficult to avoid glare at the coal-face, as the lamps have often to be placed at eye level, and their rays may shine directly into the worker's eyes. This is particularly distressing to men suffering from incipient miners' nystagmus ; an increased candle-power of new and unshaded lamps has in a few cases actually precipitated acute attacks.

30. The cap lamp, which is universally used in America, provides the best source of illumination. The light is always where required and uniform. The illumination given over the working area may be as much as ten times that given by a standard hand lamp of the same candle-power.[1] This is because the standard lamp has to be placed so much farther away and the law of inverse squares applies. There is no glare for the worker himself, but other workmen, unless fitted with similar lamps, do complain. All lamps should be shielded.

31. In order to graduate the transition from daylight to the conditions obtaining underground and to provide contrast, the travelling roads should be whitewashed or dusted with a light coloured stone. One of the earliest symptoms of miners' nystagmus is failure of dark adaptation, and the whitewashing of the travelling roads gives great comfort to the men.

32. The following illumination data, kindly supplied by Professor McMillan of Nottingham, show how far the modern lamps comply with the recommendation of the Miners' Nystagmus Committee referred to above (para. 27):—

The working area illuminated at 0.1 foot-candle and over at a distance of 4½ feet from the lamp is

With small 4-volt standard electric lamp	16 sq. feet
With large 4-volt standard electric lamp	22 ,, ,,
With modern oil lamp	22 ,, ,,
With 2-volt cap electric lamp at 2½ feet	11 ,, ,,

The cap lamp complete weighs 3¾ lb.

(B) Preliminary Examination of the Eyes

33. It is eminently desirable, in the interests of employer and employee, that there should be a preliminary examination of the eyes before a man is given underground work. Errors of refraction are common in the community generally, and it is to be expected that they will be found in a considerable proportion of men seeking employment in mines. Their discovery before underground work is begun would be of great value, because it would tend to prevent the men from regarding any difficulties of vision and associated symptoms from which they might suffer at a later stage as necessarily indicating the onset of miners' nystagmus.

34. In ordinary occupations involving much near work or eyestrain the sufferer from eyestrain is driven by distress to the discovery of his need for glasses, and to the relief by wearing glasses. But there is no such relief for the miner at the coal-face because of the practical difficulty of wearing glasses whilst at work. Thus the miner who suffers from defective sight will be liable to giddiness, headaches, and blepharospasm. Such a sufferer may sincerely believe and fear that he has miners' nystagmus ; and as the age approaches when employment becomes more uncertain the development of anxiety is almost inevitable. His mistaken but honest conviction might have been prevented if his defective sight and the cause thereof had been made known to him at his first employment.

[1] First Report of the Miners' Nystagmus Committee of the Medical Research Council, 1922, p. 39.

V.—MANAGEMENT OF CERTIFIED CASES

35. Under the conditions obtaining at present in the mining industry, once a miner has been certified by the medical referee to be suffering from miners' nystagmus he is under a very distinct disadvantage. It is difficult for him to obtain employment again in the industry ; he is under the stigma of having suffered from nystagmus, and few employers will employ him. It is felt strongly that work ought to be available for these men if they are to be prevented from drifting into hopeless neurosis. At the same time it must be recognized that many men are entirely unsuited for the hazardous occupation of mining, and cannot be allowed to become a permanent burden on the industry. This fact may be discovered after the man has been at mining for some little time, and although it may be necessary to draft him out of the industry he must to some extent be refitted for his entry into the general labour market.

36. It is suggested that those who have been examined by the proposed Medical Board and found to be suffering from miners' nystagmus should be placed in the following categories:

1. Wholly incapacitated:
   - (A) Those likely eventually to resume their previous work ;
   - (B) Those who are unsuited for the industry.
2. Partially incapacitated.
3. Not incapacitated.

The Medical Board should, in addition, be responsible for deciding what form of work, if any, the miner is capable of performing when he is found to be suffering from the disease.

37. Men placed in category 1 (A) should submit themselves for re-examination at intervals determined by the Board in order that their incapacity for work may be reviewed and a return to work made as soon as possible. Speaking generally, a man ought not to remain idle for a period of more than six months. It is desired to emphasize the opinion that by getting men back to work at an early date full working capacity would ultimately be regained and the development of neurosis prevented. A solution of the problem of who should be responsible for the employment of these men has not been attempted here.

38. Men placed in category 1 (B) should include those fit for training in vocational centres, and those who are too old for such training. Speaking generally, any miner who develops miners' nystagmus within the space of five years after commencing mining should automatically enter this category, which should also include those who suffer to a severe extent on their first attack and those who have had more than one relapse. By this means the industry would be purged of individuals who are entirely unsuitable for mining, and at the same time give them an opportunity of engaging in some other form of labour.

39. It is desirable that rehabilitation centres be formed under the control of a Government Department to enable men who are fit for vocational training to be instructed in occupations suited to their special needs. Various forms of labouring could be undertaken, such as farm labouring, road making, gardening, building labouring, etc. By this means men who are naturally unsuitable for mining would be able to make a fresh start and become useful workers in other spheres. On being discharged from the mining industry these men ought to receive a gratuity, and some form of partial compensation whilst under training.

40. The age at which a man should be thought to be too old for vocational training is considered to be 50 years. Speaking generally, when a man of this age is drafted out of the industry it is better to give him some form of

gratuity than attempt to train him for other work for which he probably feels that he is too old.

41. For men placed in category 2—that is, those partially incapacitated—surface work should be found. In many cases such work could be commenced without any intervening period of idleness. Work at the pit surface generally consists of work in the wood yard, hutch cleaning and repairing, store-keeping, greasing, the work of the tradesman's labourer, and work at the screen and picking tables, but this last is not usually satisfactory for the individual here considered.

42. At intervals to be determined by the Board a man placed in category 2 should be re-examined in order that his capacity for work may be assessed. In some cases full surface work would be recommended, and even return to work below ground might be possible. If returned to work below ground the man should be given the special consideration which is suggested below for men placed in category 3. The Medical Board should also be empowered to recommend a further period of light surface work. Generally speaking, however, a man who has not recovered his capacity for work below ground after a period of two years' work on the surface should be graded as permanently unfit for mining and drafted out of the industry.

43. In regard to men placed in category 3—that is, those not incapacitated—there should be little difficulty. These men should be allowed to return to work underground. At the same time they should receive special consideration in that they should not be sent immediately to the coal-face but should be employed on the roads, performing work on the haulage plant and doing repairs. It is essential that these men be provided with a lamp of as high candle-power as possible. After a period of this work the man might resume his employment at the coal-face. It must be recognized, however, that only men who are suffering to a very slight degree could be treated in this manner. In the event of a relapse they should be recertified.

APPENDIX

STATISTICS OF MINERS' NYSTAGMUS

1. An analysis of all the cases of miners' nystagmus occurring among the workmen insured by a mutual indemnity company over a period of years is given below:

	Percentage.
Returned to full earnings	16
Compensation stopped	8
Settled or died	12
Men on full compensation	21
Men on half difference:	
(*a*) Working	28
(*b*) Not working	15

2. In 1923, 650 cases of miners' nystagmus were examined and assessed. The following table shows the actual condition and the theoretically assessed condition of these cases. The state of the men on January 1st, 1924, is also given.

	1923		1924
	Actual Condition	Theoretically Assessed Condition	Actual Condition
Not working	468	270	167
Working on surface ...	162	154	174
Working underground...	20	226	176
Recovered	—	—	133

3. The statistics from different collieries and from the same collieries in different years vary enormously, as the following examples show:—

Pit 1.—On January 1st, 1925, the number of men receiving compensation for miners' nystagmus was two. During the year seventeen men were certified, thirteen during the summer months. They all wanted to go to the new convalescent home that had been opened in 1924. For the last seven years only fourteen cases have been certified.

Pit 2.—In 1923 seventeen men at this colliery were receiving part or full compensation. Cap lamps were introduced to improve the lighting, and for the last nine years only two cases have been reported, and the colliery has been free from miners' nystagmus for the last four years. Men employed vary from 700 to 450.

Pit 3.—With conditions unchanged the incidence varied from 0.43 to 4.44 cases per thousand in four years.

Pit 4.—Incidence: two cases in each year, 1926 and 1927, and eleven in 1928, when some of the workings were closed.

Pit 5.—In a pit employing about 500 men no cases had been reported for years, but four men were certified shortly after a number of men had been discharged.

Pit 6.—In this pit a seam employing 420 men was closed down. Fourteen claims were received at once from the men discharged, and during the whole year only seventeen claims were received from the remaining 5,400 men employed by the company.

4. The colliery managers now find it difficult to provide surface work, but the advantages of such work are shown in the table below.

Men Employed	Provision of Work	Time Worked by Pit	No. of Cases of Miners' Nystagmus	No. of Cases of Miners' Nystagmus Working	Cost
					£ s. d.
A. 1,500	Early	Good	2	1	1 12 8
B. 800	Rarely	Poor	23 (*a*)	0	15 11 9
C. 1,200	Early	Good	8	7	5 0 10
D. 1,200	Rarely	Fair	17	1	15 11 9
E. 1,200	Early	Good	12 (*b*)	10	7 16 0

A, B, and C are under the same management.

(*a*) Eight of these men were working underground until a seam closed.

(*b*) The two unemployed men are over 70, and are really pensioners.

BOOKS ADDED TO THE LIBRARY

The following books were added to the Library of the British Medical Association during March, 1936.

American Child Health Association: Physical Defects. 1934.
Anwyl-Davies, T.: Treatment of Venereal Disease in General Practice. 1935.
Bailey, H.: Emergency Surgery. Second edition. 1936.
Becker, W. S.: Commoner Diseases of the Skin. 1935.
Bordier, H., and Kofman, T.: Néodiathermie à Ondes Courtes. 1936.
Christian, H. A.: Diagnosis and Treatment of Diseases of the Heart. 1935.
Clayton, W.: Theory of Emulsions. 1935.
Comby, M. T.: Les Encéphalites Aiguës Post-infectieuses de l'Enfance. 1935.
Findlay, A.: Teaching of Chemistry in the Universities of Aberdeen. 1935.
Gamlin, R.: Modern School Hygiene. 1935.
Goldsmith, W. N.: Recent Advances in Dermatology. 1936.
Harris, L.: Vitamins in Theory and Practice. 1935.
Harrison, T. R.: Failure of the Circulation. 1935.
Harvey, W. C., and Hill, H.: Milk: Production and Control. 1936.
Henry, Sir E. R.: Classification and Uses of Finger Prints. Seventh edition. 1934.
Hinman, F.: Principles and Practice of Urology. 1935.
Hutchison, R. (Editor): Index of Treatment. Eleventh edition. 1936.
MacDermot, H. E.: History of the Canadian Medical Association. 1935.
McKie, D.: Antoine Lavoisier. 1935.
Marriott, W. McK.: Infant Nutrition. Second edition. 1935.
Marshall, C.: Introduction to Human Anatomy. 1935.
Martini's Principles and Practice of Physical Diagnosis. Edited by R. F. Loeb. 1935.
Mitchiner, P. H.: Modern Treatment of Burns and Scalds. 1935.
Odobleja, St.: La Phonoscopie. 1935.
Problem of Mental Disorder. A Study Undertaken by the Committee on Psychiatric Investigations. 1934.
Reichel, H.: Blutkörperchensenkung. 1936.
Ronald, D.: Offensive Trades. 1935.
Rosenthal, F.: Krankheiten der Leber und der Gallenwege. 1934.
Ryle, J. A.: Natural History of Disease. 1936.
Sherwood, N. P.: Immunology. 1935.
Shirokogoroff, S. M.: Psychomental Complex of the Tungus. 1935.
Singh, J.: Modern Medical Treatment. 1935.
Sutherland, H.: Tuberculin Handbook. 1936.
Suttie, I. D.: Origins of Love and Hate. 1935.
Thomson-Walker, Sir J.: Surgical Diseases and Injuries of the Genito-urinary Organs. Second edition. Edited by K. Walker. 1936.
Turner, A. L. (Editor): Diseases of the Nose, Throat and Ear. Fourth edition. 1936.
Weber, F. Parkes: Endocrine Tumours and Other Essays. 1936.
Weiss, S.: Diseases of the Liver, Gall Bladder, Ducts and Pancreas. 1935.

IRISH FREE STATE MEDICAL UNION (I.M.A. AND B.M.A.)

A meeting of the Central Council of the Irish Free State Medical Union (I.M.A. and B.M.A.) was held in the Royal College of Surgeons, Dublin, on March 26th. Dr. T. G. Moorhead was in the chair, and among those present were Drs. J. P. Shanley, E. Byrne, T. G. McGrath, J. T. Daniel, C. MacAuley, W. J. Phelan, P. J. O'Dowd, M. J. Nolan, D. F. MacCarthy, M. Finn, C. C. O'Malley, J. J. O'Connor, E. Dundon, J. W. Bigger, R. J. Rowlette, Dudley Forde, W. Meagher, P. MacCarvill, P. Cassin, E. McEnery, and D. J. Cannon.

Officers

The following provisional appointments made at the meeting on February 20th were unanimously confirmed: Dr. T. G. Moorhead, chairman; Dr. J. P. Shanley, honorary secretary; and Drs. R. J. Rowlette and C. MacAuley, joint honorary treasurers with powers to sign cheques drawn on the current account of the Union.

Adoption of By-laws

It was unanimously agreed, on the proposal of Dr. E. Byrne, seconded by Dr. McGrath: "That the printed by-laws submitted to the council be the by-laws of the Union."

Notice of Proposed Amendments of By-laws

The Central Council of the Union unanimously decided to give notice, in accordance with the provisions of Article 42, of the following proposed amendments of by-laws:

SPECIAL GROUPS—PAGE 8, BY-LAW 18

(*a*) . . . The Honorary Secretary of the Union shall cause to be sent by post to each member of the Union a form on which the member can state . . . if he wishes to be included in one of the following Special Groups of Members, namely: (i) Dispensary Medical Officers' Group; (ii) Public Health Medical Officers' Group; (iii) Medical Officers of Mental Hospitals' Group; (iv) Medical Officers of Voluntary Hospitals' Group; (v) County Hospital Surgeons' Group; (vi) Whole-time Medical Officers in the Service of the Government of Saorstat Eireann; (vii) Private Practitioners' Group; (viii) Radiologists' Group; (ix) Ophthalmic Surgeons' Group; (x) Medical Officers of Local Authority Hospital Group not provided for in any other Group. No member may elect to be included in more than one of these Groups.

(*c*) The following shall be eligible to be members of the Groups:

(i) *Dispensary Medical Officers' Group.*
Any member of the Union who is a duly appointed dispensary medical officer.

(ii) As it stands.

(iii) *Medical Officers of Mental Hospitals' Group.*
Any member of the Union who is employed in a mental hospital, whether on a full-time or part-time basis.

(iv) As it stands.

(v) *County Hospital Surgeons' Group.*
Any member of the Union who is employed by the public authorities as a county hospital surgeon.

(vi) *Whole-time Medical Officers in the Service of the Government of Saorstat Eireann Group.*
Any member of the Union who is a whole-time medical officer in the service of the Government of Saorstat Eireann.

(vii) *Private Practitioners' Group.*
Any member of the Union who is engaged in private practice, and is not included in the other groups mentioned.

(viii) *Radiologists' Group.*
Any member of the Union who practises radiology, and is not a member of any other group.

(ix) *Ophthalmic Surgeons' Group.*
Any member of the Union who is engaged as a specialist in the practice of ophthalmic surgery.

(x) *Medical Officers of Local Authorities' Hospital Group not provided for in any other Group.*
Any member of the Union who is engaged by the local authorities as medical officer of a district or cottage hospital.

VI.—CENTRAL COUNCIL—PAGE 10

By-law 23. Composition.

(*c*) Representatives of the following Special Groups of Members elected in the manner stated for one year.

(i) Dispensary Medical Officers' Group—Twelve representatives.

(ii) Public Health Medical Officers' Group—One representative up to twenty members. Two representatives if over twenty members.

(iii) Medical Officers of Mental Hospitals' Group—One representative up to twenty members. Two representatives if over twenty members.

(iv) Medical Officers of Voluntary Hospitals' Group—One representative up to twenty members. Two representatives if over twenty members.

(v) County Hospital Surgeons' Group—One representative up to twenty members. Two representatives if over twenty members.

(vi) Whole-time Medical Officers in the Service of the Government of Saorstat Eireann—One representative up to twenty members. Two representatives if over twenty members.

(vii) Private Practitioners' Group—One representative up to twenty members. Two representatives if over twenty members.

(viii) Radiologists' Group—One representative up to twenty members. Two representatives if over twenty members.

(ix) Ophthalmic Surgeons' Group—One representative up to twenty members. Two representatives if over twenty members.

(x) Medical Officers of Local Authorities' Hospitals not provided for in any other Group—One representative up to twenty members. Two representatives if over twenty members.

GROUPS COMMITTEE—PAGE 18

By-law 49.

(*a*) Committees shall be formed each year to represent each of the Special Groups of Members . . .

(*b*) Each Group Committee shall consist of:

(i) Eight members of the Group elected by the members of the Group by a postal vote . . .

But in the case of the Dispensary Medical Officers' Group, a Committee shall be formed for the Group consisting of one representative from each health area. The representative being a Dispensary Medical Officer locally elected and voted for by the Dispensary Medical Officers who are members of the Union, such election shall be at the local meeting.

EXECUTIVE COMMITTEE—PAGE 17

By-law 45.

. . . Executive Committee . . . which shall consist of . . . fifteen other members of the Central Council. . . .

In all other respects the By-laws adopted by the Central Council on March 26th, 1936, shall be the By-laws of the Union.

[Under the instructions of the Central Council of the Union and pursuant to Article 42 (ii), three months' notice of the above proposals has been given by post to all members of the Union.]

Executive Committee

An Executive Committee was appointed in accordance with By-law 45.

Diphtheria Immunization

The reply of the Department of Local Government and Public Health to a deputation from the executive of the Irish Medical Committee regarding fees for immunization against diphtheria was read. The scale of fees which the Minister stated he was prepared to sanction was considered to be inadequate. On the motion of Dr. O'Dowd, seconded by Dr. MacCarthy, the following resolution was passed unanimously:

"That the Irish Free State Medical Union (I.M.A. and B.M.A.) refuses to agree to the scale of fees offered by the Department of Local Government and Public Health for prophylactic immunization against diphtheria, and the Union advises all its members not to accept any fees less than those already approved of by the Union."

It was decided that the resolution should be inserted in the Press.

Department of Local Government and Public Health: Retirement

The recent circular letter issued by the Department of Local Government and Public Health regarding compulsory retirement at the age of 65, and in certain cases 60, was discussed. It was unanimously agreed that the Minister be asked to receive a deputation on the matter, and the following deputation was appointed: Drs. Rowlette, O'Dowd, Shanley, MacCarvill, Nolan, and Meagher. The deputation was authorized to draw up a statement for submission to the Minister.

Ethical Committee

It was agreed that an ethical committee should be set up, and the Executive Committee was empowered to do so. The following were suggested to form the committee: the Chairman, the Hon. Secretary, the Hon. Treasurer, and Drs. MacCarthy, MacCarvill, O'Dowd, and C. O'Malley. Dr. MacCarthy raised the question whether he was bound to adjudicate, if asked to do so, on the relative merits of tenants applying for labourers' cottages in cases where a dispute had arisen. Dr. MacCarthy was advised as to the action he should take in such matters.

The proceedings then terminated.

THE INSURANCE MEDICAL SERVICE WEEK BY WEEK

Punishment of Panel Doctors

Dr. Frank G. Layton thinks that there is urgent need for the establishment of a "Society for the Prevention of Cruelty to Panel Doctors." The obvious parallel where children and animals are concerned is a little unfortunate. Perhaps we may fairly reflect that insurance practitioners through their appointed representatives, the Insurance Acts Committee, enjoy a measure of protection and a share in the administration which is the envy of their Continental brethren. As a matter of fact, Dr. Layton's (admittedly humorous) suggestion arises from the indignation which he feels with regard to two Lancashire cases noted recently in this column in each of which a penalty of £25 was imposed. We have been at some pains to get further particulars of these cases, and we find that the doctor concerned, not only in these two cases but in two others reported at the same meeting of the Insurance Committee, was the same individual, and that he has not appealed against the findings of the committee in any of the four cases. There must follow from this a certain severity of comment. Medical service reports should contain, in our view, not merely a bare statement of the particulars which may be sufficient for the parties to the case, but should be as informative as possible—in the first place to enable the members of the Insurance Committee to whom the report is presented to exercise a proper judgement on the recommendations by the subcommittee, and secondly, to satisfy readers of the report, and especially the whole body of insurance practitioners, that justice is being done. In the circumstances Dr. Layton's criticisms are fair and understandable; he is saying what many are thinking. With the limited information before him it did appear to the critic that a doctor was being fined £25 for failing to respond to a message which he never received. It transpires—to use Dr. Layton's own phraseology of the police courts—that the convictions recorded would not have given rise to his comments if the reports themselves had carried conviction with them; in other words, that the sentences would not have appeared to be so severe if one or two sentences had been added to the report.

Certification After Examination by R.M.O.

As the case referred to in these notes in last week's *Supplement* has aroused a certain amount of interest, it may be as well to give the following extracts from the minutes of the meeting of the Glasgow Insurance Committee at which the case was considered.

There was submitted a letter from the practitioner stating that the patient was declared fit for work by a regional medical officer on August 29th, 1935. On that date the patient came to see him, when he suggested he should try light work. The patient maintained he was unfit for any kind of work, and intimated he was appealing against the finding of the regional medical officer. The practitioner did not think the patient was fit for work on August 29th, and continued issuing medical certificates to await the result of the appeal. The patient later told him he had been seen by the approved society's referee. He heard later that the referee had declared the patient fit for work. He was satisfied the patient was fit for work from the date he was declared fit by the society's referee.

There was submitted a copy of a report by an examining officer for the Department of Health, dated August 29th, 1935, stating that the patient had sufficiently recovered as to be no longer incapable of work.

The practitioner, on oath, stated he did not agree with the statement in the letter from the Department of Health that he agreed with the opinion of the regional medical officer that the patient was fit for work on August 29th, 1935. He first issued a certificate to the patient in respect of the illness in question on August 15th. After two weeks the patient was examined by the regional medical officer, who declared him fit for work. He saw the patient on the same day, and suggested he should try his work, but the patient said he would not as he was unfit for any kind of work. He told the patient he could try his work and then come back and let him know the result, but the patient said he was quite unfit. He gave him the benefit of the doubt. He was satisfied the patient was ill and unfit for work on August 29th. He therefore continued issuing certificates of incapacity. The patient informed him he was appealing against the decision of the regional medical officer, and he considered it his duty to continue issuing certificates to the patient until the decision of the Board had been declared. He did not receive any notification of the decision of the medical referee for the society. He expected to receive a notification. He only heard of the decision from the patient immediately prior to the hearing of the appeal on November 20th, 1935. If he had not heard of the decision he possibly would have continued to have issued certificates of incapacity. He was quite prepared to accept the decision of the referee of the approved society. He was satisfied that the patient would be fit for work when so declared by the referee to the society on September 16th, 1935. He recognized now that he should not have continued issuing certificates to the patient, and he appreciated the serious position.

After consideration of the remit and relative correspondence, and having heard the practitioner on oath, the subcommittee finds that the practitioner issued intermediate certificates, of dates September 20th and 27th and October 4th, 1935, showing that the patient was incapacitated for work by reason of anaemia and debility when, in his opinion, the patient was not incapable of work.

Incidentally in connexion with this case two departures from English practice may be noted: (1) the name of the practitioner was given in the report of the Medical Service Subcommittee, and (2) evidence was taken on oath.

Meetings of Branches and Divisions

BURMA BRANCH

The annual general meeting of the Burma Branch was held at Rangoon on January 29th, when, before proceeding with the business of the meeting, the PRESIDENT paid a tribute to the memory of the late Dr. N. N. Parekh, who had been president of the Branch.

The following officers were elected for 1936:

President, Lieut.-Col. E. Cotter, I.M.S. *Vice-President,* Dr. J. S. Laurie. *Honorary Secretary and Treasurer,* Dr. J. W. Lusk. *Representative in Representative Body,* Dr. N. J. Patterson. *Deputy Representative in Representative Body,* Lieut.-Col. J. Findlay, I.M.S.

The report of the Branch for 1935 was considered and approved.

CALCUTTA BRANCH

The annual general meeting of the Calcutta Branch was held at Calcutta on January 17th, when Rai Dr. U. N. ROY CHAUDHURI BAHADUR was in the chair.

The annual reports of the Branch Council, the honorary treasurer, and the honorary secretary were read and adopted, and the following officers were elected:

President and Representative in Representative Body, Lieut.-Col. E. W. O'G. Kirwan, I.M.S. *Vice-Presidents,* Lieut.-Col. E. H. V. Hodge, I.M.S., and Rai Dr. U. N. Roy Chaudhuri Bahadur. *Honorary Treasurer,* Dr. A. J. H. de Monte. *Honorary Secretary,* Dr. J. P. Chaudhuri. *Deputy Representative in Representative Body,* Brevet Colonel R. N. Chopra, C.I.E., I.M.S.

CEYLON BRANCH

At a meeting of the Ceylon Branch, held at Colombo on January 29th, with the president, Dr. J. R. BLAZE, in the chair, Dr. R. BRIERCLIFFE was elected representative in the Representative Body.

The PRESIDENT then delivered his inaugural address, on "Nervous Diseases in Ceylon." The meeting closed with a vote of thanks to Dr. Blaze for his address.

DORSET AND WEST HANTS BRANCH: BOURNEMOUTH DIVISION

A meeting of the Bournemouth Division was held at Boscombe Hospital on March 25th, when Dr. F. W. BRODERICK was in the chair and fifty-six members were present. The SECRETARY proposed that the Bournemouth Division and the Dorset and West Hants Branch areas remain as at present constituted, and this was seconded by Dr. S. WATSON SMITH.

The CHAIRMAN exhibited an ultramicroscopic film of blood plasma showing protein particles displaying Brownian movements. He said that his was the first film ever made of protein particles, although there had been earlier attempts to do so. While it was by no means perfect, it was well worth showing.

The Chairman then introduced Mr. J. E. R. McDonagh, and said they would listen to a speaker who viewed the origins of disease in a spirit which differed profoundly from orthodox teaching. He had studied Mr. McDonagh's writings and had read extensively of the science of colloid chemistry in so far as it was related to biology and medicine, and had found nothing that was contrary to Mr. McDonagh's teachings. He asked for sympathetic hearing of the paper, which should not be condemned without investigation.

Mr. McDONAGH then read his paper on "Life, Disease, and Death." Mr. McDonagh observed that Nature appeared to work to a single pattern, and that in all sciences there was a rough similarity which formed their groundwork. From his own researches into the chemico-physical properties of the protein particles of the blood plasma he had attempted to visualize the evolution of the universe. Through the uneven distribution of "energy" or "activity" there came about places of greater concentration, which increased to such a size that they disintegrated, producing cosmic radiation. Through this stage of subatomic development there arose by a continuation of the same processes of condensation an atomic stage in which the chemical compounds were formed.

In course of time, following the same plan, Nature produced the colloids, through which life became possible. The same processes that were responsible for the production of matter in the colloidal state still being active and regulating the physico-chemical properties of the colloids were responsible for the development of disease, either by concentration of actively producing enlarged hydrated colloidal particles or by dissipation into small dehydrated particles. In the latter case the particles tended to pass into true solution, and in the former into coarse dispersion and precipitation.

Further, Mr. McDonagh showed how a disequilibrium of condensation between the protein particles in the plasma (the dynamic particles) and those in the cells of the tissues (the static particles) would, according to the same laws, bring about changes in the structure of the tissues of organs and tissues which are associated with disease. He emphasized that the signs and symptoms of the disease were the consequence of the precipitation of the hydrated colloidal protein particles rather than of the agent which initiated the process. Thus there was in reality only one disease, in that all the agents which caused disease acted in the same way.

Pursuing this line of argument, Mr. McDonagh contended that treatment must act precisely as the invader did, be this a micro-organism or a chemical poison. Disease resulted when an invader abstracted activity from a normal protein particle, whereas treatment should set free activity from hydrated protein particles to restore energy to the particles which had been robbed. He showed how treatment should differ according to whether the disease was acute, subacute, or chronic, and how drugs could be built up synthetically for this purpose. He brought into the story not only the newer chemotherapeutic drugs, but also vaccines, physiotherapy, and homoeotherapy.

After many questions had been asked a very hearty vote of thanks was accorded Mr. McDonagh, on the motion of the CHAIRMAN, for his interesting and thought-provoking address, and to Mr. Torrens for the excellent film he had produced.

SUDAN BRANCH

Meetings of the Sudan Branch were held at Khartum on November 11th and December 9th, 1935, and on January 13th and February 3rd, when Dr. E. D. PRIDIE was in the chair, except at the January meeting, when Sir ROBERT G. ARCHIBALD presided.

On November 11th, 1935, Dr. E. S. HORGAN read a paper on "Recent Studies in Influenza." Dr. Horgan said that the earlier attempts to isolate a filterable virus gave most conflicting results, and modern advances really began with the discovery by Laidlaw and Dunkin of the ferret as a susceptible animal to the intranasal instillation of influenza virus. The important work of Shope on swine influenza in the United States of America and its bearing on the problems of human influenza was also dealt with. The discussion was opened by Dr. R. M. HUMPHREYS, and many members took part. A vote of thanks was accorded to Dr. Horgan for his interesting paper.

Nutritional Anaemias

At the December meeting Dr. R. M. HUMPHREYS read a paper on "Nutritional Anaemias." The paper was confined to the forms of nutritional anaemias seen in Khartum Hospital. Dr. Humphreys gave a brief description of normal erythropoiesis and the factors responsible for the maturation of the red blood corpuscles. He said that the pernicious anaemia factor, which was formed in the stomach and stored in the liver, consisted of two parts: intrinsic, present in normal gastric juice; and extrinsic, present in normal diet. Deficiency of either the intrinsic or extrinsic factors might well result in an anaemia of the megalocytic type. Iron, the absence of which gave rise to microcytic anaemia, might be deficient in daily food, or it might be present and not absorbed.

Two types of nutritional anaemia in pregnancy or during lactation were described.

Mild Type.—This usually occurred about the middle of the gestation period, with gastric discomfort, vomiting, or diarrhoea, together with glossitis and pallor of the mucous membranes, and all the symptoms of anaemia. The red cell count was reduced to the region of 2 to 4 millions, with a low colour index and an achlorhydria. In other cases there was no complaint of the common symptoms of anaemia, but the woman sought advice because her previous pregnancies had ended prematurely in abortion or miscarriage.

Severe Type.—This might occur during gestation, but was usually seen during lactation about one to two months after confinement. In contrast with the pale, listless, debilitated mother, the child was chubby, fat, and lively, with no apparent anaemia. There was usually a history of diarrhoea and fever for a long period for which no cause could be found. There was enlargement of the liver and spleen, and oedema of the legs and sacrum, with puffiness of the face. Anaemia was usually profound; the total of the red blood cells was a million or less; the colour index was high, and many megalocytes were seen in the blood film. In treatment iron for the hypochromic type given throughout gestation was successful, a full-term live child resulting In the severe cases blood transfusion, followed by raw liver and iron, was advocated.

Anaemia accompanying sprue might be either microcytic, megalocytic, or aplastic, depending on the stage of the disease. Treatment consisted in a fat-free diet, with raw liver and iron. Anaemia due to ankylostomiasis was of the hypochromic type, with a low colour index. It had been found that this anaemia could be cured temporarily by the administration of large doses of iron.

The discussion was opened by Dr. R. KIRK, who suggested that the achylia might be the initial lesion, and referred to the fact that work in England and in America showed the achylia depended on a hereditary factor, and was the only obvious indication of a hereditarily vulnerable mucosa. He further suggested that those anaemias, though microcytic and megalocytic in type, might be stages in the same series, and that one might turn into the other. He understood that in India, on the other hand, a different type of megalocytic anaemia had been described which was not associated with achylia; this might be an entirely different pathological condition. Dr. R. H. BLAND said that he had found the anaemias of gestation most common in Greek and Syrian patients. The addition of spices and lime-juice to the liver had been found to be of benefit.

The meeting closed with a vote of thanks to Dr. Humphreys for his interesting paper.

At the January meeting the CHAIRMAN welcomed Sir Walter Langdon-Brown, Dr. Soper, Dr. Badri, Dr. Hussein, Dr. Atabani, and Dr. Dafa'allah as the guests of the evening.

Malaria in the Sudan

Dr. L. H. HENDERSON read a paper on "Malaria in the Sudan: its Prevention, Control, and Treatment." Dr. Henderson recounted his experiences in the use of quinine, plasmoquine, and atebrin. His conclusions were that quinine should be taken only if the patient was remote from medical attention, and then in small doses. Plasmoquine was inadequate in ordinary therapeutic doses, but good results were being obtained with two tablets twice weekly of "kombinationstablettin," a Bayer preparation containing 0.1 gram of atebrin plus 0.005 gram of plasmoquine. The similarity of the action of quinine, plasmoquine, and atebrin in stimulating the natural defensive mechanism of the body was discussed. The delaying of specific treatment until the patient's natural resistance had been stimulated by one or more paroxysms was advocated for cases not otherwise in immediate danger from

either the disease itself or other intercurrent infection. Care in the use of either atebrin or plasmoquine in the presence of cardiac disease or marked liver deficiency was advised. Atebrin and plasmoquine were generally recommended for primary infections, and quinine and plasmoquine for relapses. These combinations, given in small doses for short periods only, were, in the speaker's experience, rarely associated with symptoms of hypersensitiveness. Attention was drawn to the inadvisability of giving quinine by injection unless specifically indicated. The discussion was opened by Dr. R. M. HUMPHREYS, and many members took part. A vote of thanks was accorded Dr. Henderson for his interesting paper.

The annual general meeting of the Branch was held on February 3rd, when the following officers were elected:

President, Dr. E. D. Pridie, D.S.O., O.B.E. *Vice-President,* Dr. F. S. Mayne. *Honorary Secretary and Treasurer,* Dr. D. R. Macdonald.

The attention of members was drawn to the dates of the Annual Meeting of the British Medical Association at Oxford, and to the expenses allowed to members acting as representatives.

LINCOLNSHIRE BRANCH: LINCOLN DIVISION

The first annual dinner of the Lincoln Division was held on March 26th, when Dr. WILLIAM SHARRARD was in the chair and over fifty members and their ladies were present. The guests of honour were the Bishop of Grimsby and Mrs. Blackie, Judge Langman and Mrs. Langman, and Councillor Mills, the chairman of the Health Committee of the Lincoln Borough Council. The CHAIRMAN proposed the loyal toast. Judge LANGMAN, in a brilliant and witty speech, proposed "The Prosperity of the Lincoln Division," and Dr. R. B. PURVES responded. The health of the visitors was proposed by Dr. G. C. WELLS-COLE, and the BISHOP OF GRIMSBY and Councillor MILLS replied. The evening concluded with songs and musical sketches.

Correspondence

PUNISHMENT OF PANEL DOCTORS

SIR,—If Dr. F. G. Layton is so dissatisfied with the Panel Service owing to the fines imposed, where they have been after full inquiry, one wonders why he remains in the service. In all services there must be rules and regulations, and penalties to act as deterrents. He cannot surely think it fair either to the insured person or to the doctor to whom the patient has transferred that the medical record card should be held up for any period after ten days' notice. His comparisons are clearly ridiculous and require no comment. He is evidently unaware of the good defensive work done by Panel Committees for doctors generally, and complaints against them. These representatives are in the hands of the profession alone.—I am, etc.,

Essex, April 17th. "N."

A MEDICAL SERVICE SUBCOMMITTEE CASE

SIR,—Referring to my letter in the *Supplement* of April 4th (p. 133), Dr. McNamara asks for my authority for saying that "if a fee be not forthcoming the doctor is under no obligation to provide treatment." My statement is based on a common-sense reading of Clause 7 (2) of the Terms of Service. This clause is the only protection which the insurance practitioner has against fraud. There would be no point in giving the doctor power to charge a fee and at the same time require him to give his services when the fee was refused. That would open the door to unlimited victimization of the doctor. Any person could go to the doctor and say he was insured without producing any evidence. Neither the Minister of Health nor anyone else has any right to compel an insurance practitioner to treat without charge any or all of the uninsured population who choose to say they are insured.—I am, etc.,

C. LUTHER BATTESON,
Medical Secretary, London Panel Committee.

17, Russell Square, W.C.1,
April 17th.

Naval, Military, and Air Force Appointments

ROYAL NAVAL MEDICAL SERVICE

Surgeon Commanders M. Brown to the *Frobisher*; R. W. Nesbitt to the *President*, for course; T. J. O'Riordan to the *Royal Sovereign*; L. F. Strugnell and E. L. Markham, O.B.E., to the *Pembroke*, for Royal Naval Barracks; H. H. Babington to the *President*, for Royal Naval Recruiting Headquarters.

Surgeon Lieutenant Commander F. B. Quinn to be Surgeon Commander.

Surgeon Lieutenant Commander T. W. Froggatt to the *Pembroke*, for Royal Naval Hospital, Chatham.

Surgeon Lieutenants F. W. A. Fosbery to the *Lupin*; M. A. Rugg-Gunn to the *Repulse*; W. W. Simkins to the *Ganges*.

The following Surgeon Lieutenants have been transferred to the permanent list, with original seniority indicated in parentheses: W. W. Simkins (January 24th, 1932); W. J. F. Guild (February 20th, 1932); F. W. Chippindale (April 9th, 1932); M. G. Ross (May 8th, 1932); W. A. Ryan (May 17th, 1932); D. D. Steele-Perkins (September 8th, 1932); G. H. C. Southwell-Sander (September 15th, 1932); G. A. Lawson (November 22nd, 1932); and C. P. Collins (December 7th, 1932).

ROYAL NAVAL VOLUNTEER RESERVE

Surgeon Lieutenant Commander A. R. Thomas to the *Encounter*.

Surgeon Lieutenant G. F. Jones to the *Drake*, for Royal Naval Barracks.

Surgeon Sublieutenant R. T, Gaunt to be Surgeon Lieutenant.

Probationary Surgeon Lieutenant R. R. Prewer to the *Victory*, for Royal Naval Hospital, Haslar.

ARMY MEDICAL SERVICES

Colonel N. Low, D.S.O., O.B.E., late R.A.M.C., having attained the age for retirement, has been placed on retired pay.

Lieut.-Col. F. R. Coppinger, O.B.E., from R.A.M.C., to be Colonel.

ROYAL ARMY MEDICAL CORPS

Lieut.-Col. R. Gale, D.S.O., has been placed on the half-pay list on account of ill-health.

Majors C. D. M. Buckley, M.C., and J. C. A. Dowse, M.C., to be Lieutenant-Colonels.

Lieutenants O. R. L. L. Plunkett and A. MacLennan to be Captains, with seniorities October 25th, 1934, and June 1st, 1935, respectively.

The appointments of Lieutenants O. R. L. L. Plunkett and A. MacLennan have been antedated to October 25th, 1933, and June 1st, 1934, respectively, under the provisions of Article 36, Royal Warrant for Pay and Promotion, 1931, but not to carry pay and allowances prior to October 25th, 1934, and April 1st, 1935, respectively.

REGULAR ARMY RESERVE OF OFFICERS

ROYAL ARMY MEDICAL CORPS

Major J. W. Houston, D.S.O., having attained the age limit of liability to recall, has ceased to belong to the Reserve of Officers.

TERRITORIAL ARMY

ROYAL ARMY MEDICAL CORPS

Lieut.-Col. S. J. C. Holden, T.D., has retired on account of ill-health, and retains his rank with permission to wear the prescribed uniform.

Captain F. A. Belam, late R.A.M.C., S.R., to be Captain, with seniority February 11th, 1934.

Lieutenant H. Dickie to be Captain.

INDIAN MEDICAL SERVICE

Brevet Col. H. H. Thorburn, C.I.E., Officiating Inspector-General of Civil Hospitals and Prisons and Director of Public Health, North-West Frontier Province, has been confirmed in that appointment as from March 4th.

Majors A. C. Craighead, P. H. S. Smith, and H. J. H. Symons, M.C., to be Lieutenant-Colonels.

On reversion from foreign service under the Indian Research Fund Association, Major W. H. Mulligan has been appointed as officiating Assistant Director, Central Research Institute, Kasauli, vice Lieut.-Col. W. J. Webster, granted leave.

Captains M. K. Afridi and G. S. Chawla to be Majors.

The services of Captain B. Temple-Raston have been placed temporarily at the disposal of the Government of the Punjab as from March 12th, 1935.

The services of Captain S. M. K. Mallick have been placed at the disposal of the Government of the Punjab as from February 22nd, for appointment as Principal, Medical School, Amritsar.

Captain B. F. B. Russell has been appointed to officiate as Executive Officer, Saugor Cantonment, in addition to his ordinary duties, vice Lieutenant Deman Singh Negi, proceeded on leave.

The services of Captains A. K. Gupta and B. N. Hajra have been placed temporarily at the disposal of the Government of Bengal as from December 25th, 1935.

Captain M. K. Afridi has been appointed to the Medical Research Department on probation for two years, and has been placed on foreign service under the Indian Research Fund Association as from January 4th.

Captain C. J. H. Brink has been appointed as Air Port Health Officer, Karachi, as from December 23rd, 1935.

The probationary appointment of Captain R. L. Raymond has been confirmed.

Lieutenant (on probation) J. F. A. Forster to be Captain (on probation), with seniority June 24th, 1935.

To be Lieutenants (temporary commissions): H. L. Khosla, N. M. Durrani, S. P. Wanchoo, S. C. Misra, and S. Rameshwar.

To be Lieutenants (on probation): W. McN. Niblock and H. J. Gibson (seniorities December 27th, 1934), P. A. Hubbard, T. P. Mulcahy, F. E. McLaughlin, E. H. Wallace, and S. W. Allinson (seniority January 13th, 1935).

Association Notices

BRANCH AND DIVISION MEETINGS TO BE HELD

BIRMINGHAM BRANCH: WEST BROMWICH AND SMETHWICK DIVISION.—At West Bromwich and District General Hospital, Thursday, April 30th, 8.15 p.m. Agenda: Maternal mortality; fees for administration of anaesthetics in connexion with dental benefit; and film dealing with the production of antitoxins, prophylactics, and vaccine lymph.

EDINBURGH BRANCH: SOUTH-EASTERN COUNTIES DIVISION.—At Royal Hotel, Galashiels, Wednesday, April 29th, 3 p.m. Annual meeting. Election of officers, etc.

FIFE BRANCH.—At Station Hotel, Kirkcaldy, Thursday, April 30th, 3.30 p.m. Clinical meeting. Address by Dr. R. F. Mudie: "Economic Prescribing."

KENT BRANCH: DARTFORD DIVISION.—At City of London Mental Hospital, Stone, Dartford, Friday, April 24th, 8.45 p.m. Dr. T. Farthing: "Problems of Infectious Diseases in Relation to Private Practice."

KENT BRANCH: EAST KENT DIVISION.—At Grand Hotel, Cliftonville, Thursday, April 30th, 8.45 p.m. Election of representatives and deputy representatives. Paper by Mr. C. P. G. Wakeley: "Head Injuries." Preceded by small dinner at 7.45 p.m.

METROPOLITAN COUNTIES BRANCH: CITY DIVISION.—At Metropolitan Hospital, Kingsland Road, E. Friday, April 24th, 4.30 p.m. Dr. C. C. Worster-Drought: Neurological cases. Tuesday, April 28th, 9.30 p.m., demonstration by Dr. Guy Bousfield on diphtheria immunization.

METROPOLITAN COUNTIES BRANCH: KENSINGTON DIVISION.—At Princess Louise Kensington Hospital for Children, St. Quintin Avenue, W., Friday, April 24th, 8.45 p.m. Annual general meeting.

METROPOLITAN COUNTIES BRANCH: WILLESDEN DIVISION.—At Paddington Green Children's Hospital, W., Wednesday, April 29th, 3 p.m. Demonstration of selected cases by Dr. T. Pearse Williams.

NORFOLK BRANCH.—At Norfolk and Norwich Hospital, Wednesday, April 29th, 3.30 p.m. Assistant Commissioner William C. Bentall, O.B.E., F.R.C.S.Ed. (Air Raid Precautions Staff Officer to Chief Commissioner, St. John Ambulance Brigade): "War Gases and their Relation to Modern Air Raid Precautions."

NORTHERN IRELAND BRANCH.—At King Edward Hall, Royal Victoria Hospital, Belfast, Thursday, May 7th. 10.30 a.m., annual meeting; 1.15 p.m., luncheon, at the invitation of the president, at Grand Central Hotel.

SOUTHERN BRANCH: WINCHESTER DIVISION.—At Royal Hampshire County Hospital, Winchester, Wednesday, April 29th, 8.30 p.m. Mr. Robert Milne: "Pain in the Fore Part of the Foot."

SOUTH-WESTERN BRANCH: TORQUAY DIVISION.—At Electricity Hall, Town Hall, Castle Circus, Torquay, Wednesday, April 29th, 8.30 p.m. B.M.A. Film of the World Tour, 1935. At Torbay Hospital, Torquay, Thursday, May 7th, 4 p.m. Annual general meeting. Election of officers. Consideration of adoption of resolution, etc.

SUSSEX BRANCH: WEST SUSSEX DIVISION.—At Royal West Sussex Hospital, Chichester, Friday, May 1st, 3 p.m. Clinical meeting.

WORCESTERSHIRE AND HEREFORDSHIRE BRANCH: HEREFORD DIVISION.—At 1A, St. John Street, Hereford, Friday, May 1st, 3.30 p.m. Consideration of adoption of resolutions, etc.

DIARY OF SOCIETIES AND LECTURES

ROYAL SOCIETY OF MEDICINE

Section of Odontology.—Mon., 8 p.m. Mr. G. T. Hankey: Complete Caries of Erupted Permanent Dentition at the Age of 13—Agenesia of the Enamel. Dr. A. MacGregor: An Experimental Investigation of the Lymphatic System of the Teeth and Jaws.

Section of Medicine.—Tues., 4 p.m. Clinical Meeting at Charing Cross Hospital.

Section of Otology.—Fri., 10.30 a.m. (Cases at 9.30 a.m.) Annual General Meeting. Election of Officers and Council for 1936-7. Dr. G. V. Th. Borries (Copenhagen): Diagnostic Problems in Otogenous Intracranial Complications. Mr. T. E. Cawthorne: Prescription of Aids to Hearing.

Section of Laryngology.—Fri., 5 p.m. (Cases at 4 p.m.) Annual General Meeting. Election of Officers and Council for 1936-7. Mr. W. S. Thacker Neville: Treatment of Quinsy by Tonsillectomy. Discussion: Headache Associated with Disease in the Nose. Openers: Dr. G. V. Th. Borries, Mr. F. J. Cleminson, Dr. Gavin Young.

Section of Anaesthetics.—Fri., 8.30 p.m. Annual General Meeting. Election of Officers and Council for 1936-7. Dr. E. P. Poulton: Future of the Oxygen Tent.

Section of Neurology.—Fri. and Sat., Meeting in Amsterdam. May 1st: Arrive Amsterdam, 7.50 a.m. Morning: Demonstrations at the Neurological Centrum and presentation of cases in the wards by Prof. B. Brouwer. Afternoon: Meeting of the Amsterdamsche Neurologen Vereeniging. Clinical subjects and pathological specimens by the chiefs of the neurological departments of different hospitals. Evening: Dinner with Prof. and Mrs. Brouwer. May 2nd: Morning: Demonstration of neurosurgical cases by Dr. Oljenick. Luncheon with committee of Amsterdamsche Neurologen Vereeniging.

Section of Odontology.—Fri. and Sat., Meeting in Birmingham by invitation of the Odontological Section of the Birmingham Medical Institute. May 1st: 7 p.m., Reception at Union Club by the president, Mr. C. H. Howkins; 7.15 p.m., Dinner; Paper by Mr. C. M. Strong, Some Considerations of the Pathology and Treatment of Dental Infections of the Antrum. May 2nd: 10 a.m., at Medical Institute, Mr. Harold Round and Dr. H. J. R. Kirkpatrick, Further Investigations on Bacteriological Infections of the Mouth. 11.15 a.m., Clinical cases by Mr. Hugh Donovan, Mr. Russell Green, Dr. Baylis Ash, Prof. Humphreys, Mr. Harold Round, Colonel Broderick, Mr. Sampson, and Mr. Strong. Demonstration of the Injection Technique for taking Plaster Impression, by Mr. John Bunyan. 12.45 p.m., Luncheon at Midland Hotel.

BRITISH RED CROSS SOCIETY, 9, Chesham Street, S.W.—*Fri.*, 5 p.m. Lecture on Air Raid Precautions.

WEST LONDON MEDICO-CHIRURGICAL SOCIETY.—At West London Hospital, Hammersmith Road, W., *Fri.*, 8.45 p.m. Discussion: Diseases of the Stomach. Openers, Sir James Walton, Dr. Maurice Shaw, Prof. E. C. Dodds, and Dr. H. W. A. Post. Preceded by cases at 8 p.m.

British Medical Association

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Diary of Central Meetings

APRIL

30 Thurs. Ophthalmic Committee, 2.30 p.m.

MAY

1 Fri. Grants Subcommittee, 2.30 p.m.
6 Wed. Central Ethical Committee, 2.30 p.m.
7 Thurs. Charities Committee, 2.30 p.m.
8 Fri. Public Health Committee, 2 p.m.
12 Tues. Pathologists Group Committee, 9.30 a.m.
15 Fri. Public Medical Services Subcommittee, 2.15 p.m.

POST-GRADUATE COURSES AND LECTURES

BRITISH POST-GRADUATE MEDICAL SCHOOL, Ducane Road, W.—*Daily,* 10 a.m. to 4 p.m., Medical Clinics, Surgical Clinics or Operations, Obstetric and Gynaecological Clinics or Operations. *Mon.,* 2.15 p.m., Dr. Duncan White, Radiological Demonstration; 3.30 p.m., Mr. Frank Cook, Dysmenorrhoea. *Tues.,* 2 p.m., Prof. Kettle, Pathological Demonstration; 3 p.m., Dr. Miles, Extensions of the Widal Test. *Wed.,* 12 noon, Clinical and Pathological Conference (Medical); 2.30 p.m., Clinical and Pathological Conference (Surgical). *Thurs.,* 2.30 p.m., Dr. W. S. C. Copeman, Arthritis; 3 p.m., Dr. Chassar Moir, Operative Obstetrics. *Fri.,* 2.15 p.m., Dr. A. A. Davis, Gynaecological Pathology; 5 p.m., Sir James Walton, The Surgical Aspects of Dyspepsia.

FELLOWSHIP OF MEDICINE AND POST-GRADUATE MEDICAL ASSOCIATION, 1, Wimpole Street, W.—*Maudsley Hospital,* Denmark Hill, S.E.: Afternoon Course in Psychological Medicine. *Royal Waterloo Hospital,* Waterloo Road, S.E.: All-day Course in Medicine, Surgery, and Gynaecology. *Infants Hospital,* Vincent Square, S.W.: Sat. and Sun., Week-end Course in Infants' Diseases. Courses are open only to members and associates of the Fellowship of Medicine.

CENTRAL LONDON THROAT, NOSE AND EAR HOSPITAL, Gray's Inn Road, W.C.—*Daily*, Course in Anatomy and Physiology for Part I of the D.L.O. Examination.

HOSPITAL FOR SICK CHILDREN, Great Ormond Street, W.C.—*Wed.*, 2 p.m., Clinical Lecture, Dr. Wilfrid Sheldon, Oesophageal Obstruction. 3 p.m., Clinico-Pathological Lecture, Dr. G. H. Newns, Morbid Anatomy of the Intestinal Tract. Out-patient clinics, mornings, 10 a.m. to 12 noon. Ward Visits, afternoons, 2 p.m. to 3.30 p.m.

INSTITUTE OF PATHOLOGY AND RESEARCH, St. Mary's Hospital, W.—*Tues.*, 5 p.m., Sir Joseph Barcroft, F.R.S., The Genesis of Respiratory Movements in the Foetal Sheep.

NATIONAL HOSPITAL FOR DISEASES OF THE HEART, Westmoreland Street, W.—*Tues.*, 5.30 p.m., Dr. John Parkinson, Aneurysm.

ABERDEEN MEDICAL SCHOOL.—At Royal Aberdeen Hospital for Sick Children: *Tues.* and *Thurs.*, 3.15 p.m., Dr. William Brown, Diagnosis and Treatment of Endocrine Disorders of Childhood.

BIRMINGHAM UNIVERSITY.—At Medical Faculty Buildings, Edmund Street: *Thurs.*, 4 p.m., William Withering Lecture by Prof. W. W. C. Topley, F.R.S.: The Mechanisms of Immunity—the Antigen-Antibody Reactions.

GLASGOW POST-GRADUATE MEDICAL ASSOCIATION.—At Western Infirmary: *Wed.*, 4.15 p.m., Mr. J. Mill Renton, Toxic Goitre and its Treatment.

GLASGOW UNIVERSITY.—At Ophthalmic Department of the University, Tennent Memorial Building, Church Street: *Mon.*, 5 p.m., Prof. Brückner (Basle), Endogen and Exogen Factors in their Relation to the Origin of Some Diseases of the Eye.

MANCHESTER ROYAL INFIRMARY.—*Tues.*, 4.15 p.m., Mr. Wilson H. Hey, Round About Peptic Ulcer. *Fri.*, 4.15 p.m., Dr. William Brockbank, Demonstration of Medical Cases.

VACANCIES

ACTON HOSPITAL, W.—Hon. Consulting P.

ALTRINCHAM GENERAL HOSPITAL.—J.H.S. Salary £120 p.a.

BIRMINGHAM AND MIDLAND EYE HOSPITAL.—R.S.O. Salary £200 p.a.

BIRMINGHAM CITY.—Whole-time J.M.O. (male) at the Selly Oak Hospital. Salary £200 p.a.

BOLINGBROKE HOSPITAL, Wandsworth Common, S.W.—H.S. (male). Salary £120 p.a.

BRADFORD ROYAL INFIRMARY.—Two H.S. (males, unmarried). Salaries £135 p.a. each.

BRIDGWATER GENERAL HOSPITAL.—H.S. Salary £130-£150 p.a.

BRISTOL CITY AND COUNTY.—J.A.R.M.O. at Southmead Municipal General Hospital. Salary £200 p.a.

CANTERBURY: KENT AND CANTERBURY HOSPITAL.—H.S. (male, unmarried). Salary £125 p.a.

CHESTER CITY.—Senior R.M.O. (male) at the City Hospital. Salary £400 p.a.

COVENTRY AND WARWICKSHIRE HOSPITAL.—(1) R.H.P. (2) R.H.S. Salaries £160 p.a. and £125 p.a. respectively

DERBY COUNTY BOROUGH.—A.R.M.O. (male) at Derby City Hospital. Salary £200 p.a.

DONCASTER ROYAL INFIRMARY.—(1) Resident Anaesthetist. (2) H.S. Males. Salaries £175 p.a. each.

EASTBOURNE: ROYAL EYE HOSPITAL.—Non-resident H.S. Salary £100 p.a.

EDINBURGH: ROYAL INFIRMARY.—Whole-time Junior Assistant Radiologist. Salary £150 p.a.

ESSEX COUNTY.—Coroner for the Southern and Western and Writtle and Roxwell Districts. Salary £1,000 p.a.

FRODSHAM: LIVERPOOL SANATORIUM.—Second Assistant (male, unmarried) to the Medical Superintendent. Salary £200 p.a.

GLASGOW CORPORATION.—Deputy Medical Superintendent at the Southern General Hospital. Salary £500-£20-£600 p.a.

GREAT BARROW: EAST LANCASHIRE TUBERCULOSIS COLONY.—H.P. (male). Salary £150 p.a.

GROCERS' COMPANY, Grocers' Hall, E.C.—Three Medical Research Scholarships. Value £300 p.a.

HASTINGS: ROYAL EAST SUSSEX HOSPITAL.—Locumtenent H.S. (female). Salary £5 5s. per week.

HESTON AND ISLEWORTH BOROUGH.—Assistant M.O.H. and School M.O. (male). Salary £500-£25-£700 p.a.

HOME OFFICE (CHILDREN'S BRANCH), S.W.—Medical Inspector (male). Salary £738-£30-£1,058 p.a.

HOSPITAL FOR SICK CHILDREN, Great Ormond Street, W.C.—(1) R.M.O. (unmarried) at the Country Branch Hospital, Tadworth. (2) Part-time Surgical Registrar (male). Salaries £250 p.a. and £200 p.a. respectively.

HULL ROYAL INFIRMARY.—Second C.O. (male, unmarried). Salary £150 p.a.

IPSWICH: EAST SUFFOLK AND IPSWICH HOSPITAL.—(1) S. in charge of Orthopaedic Department and Fracture Clinic. (2) C.O. (3) H.S. Males. Salaries £500 p.a., £168 p.a., and £144 p.a. respectively.

KINGSTON-UPON-HULL CITY AND COUNTY.—A.M.O. (male) at Beverley Road Institution. Salary £350 p.a.

LONDON JEWISH HOSPITAL.—(1) R.M.O. and H.P. Salary £150 p.a. (2) H.S. (3) C.O. Males. Salaries £100 p.a. each.

LONDON UNIVERSITY, South Kensington, S.W.—Thomas Smythe Hughes Medical Research Fund.

MACCLESFIELD GENERAL INFIRMARY.—Second H.S. Salary £150 p.a.

MANCHESTER: MANCHESTER ROYAL INFIRMARY AND UNIVERSITY OF MANCHESTER.—Dickinson Scholarships: (*a*) Travelling Scholarship in Medicine, and (*b*) Scholarship in Surgery. Values £300 and £75 respectively.

MANCHESTER: ROYAL MANCHESTER CHILDREN'S HOSPITAL.—R.S.O. (unmarried). Salary £125 p.a.

MERTHYR GENERAL HOSPITAL.—R.H.S. Salary £150 p.a.

MEXBOROUGH: MONTAGU HOSPITAL.—J.H.S. (female). Salary £100 p.a.

NORTHAMPTON GENERAL HOSPITAL.—Two H.S. (males). Salaries £150 p.a. each.

NOTTINGHAM: CITY MENTAL HOSPITAL.—J.A.M.O. Salary £350-£25-£450 p.a. Male, unmarried.

NOTTINGHAM GENERAL DISPENSARY.—Resident S. (female, unmarried). Salary £250-£25-£300 p.a.

OXFORD: WINGFIELD-MORRIS ORTHOPAEDIC HOSPITAL.—Lord Nuffield Scholarship in Orthopaedic Surgery (male).

PENSHURST: CASSEL HOSPITAL FOR FUNCTIONAL NERVOUS DISORDERS.—Locumtenents (male). Salaries £10 10s. per week each.

PRINCESS BEATRICE HOSPITAL, Earl's Court, S.W.—R.M.O. (male). Salary £150 p.a.

PRINCESS ELIZABETH OF YORK HOSPITAL FOR CHILDREN, Shadwell, E. R.M.O. (male). Salary £200 p.a.

PRINCESS LOUISE KENSINGTON HOSPITAL FOR CHILDREN, St. Quintin Avenue, W.—H.S. Salary £100 p.a.

QUEEN'S HOSPITAL FOR CHILDREN, Hackney Road, E.—Clinical Assistant to Surgical Out-patients. Honorarium 5s. per attendance.

RADCLIFFE-ON-TRENT: NOTTS COUNTY MENTAL HOSPITAL.—Second A.M.O. (male). Salary £459-£25-£559 p.a.

ROTHERHAM HOSPITAL.—H.P. (male). Salary £180 p.a.

ROYAL CHEST HOSPITAL, City Road, E.C.—(1) R.M.O. (2) H.P. Salaries £150 p.a. and £100 p.a. respectively.

ROYAL SOCIETY, Burlington House, W.—E. Alan Johnston and Lawrence Research Fellowship in Medicine. Stipend £700 p.a.

ROYAL WATERLOO HOSPITAL FOR CHILDREN AND WOMEN, S.E.—(1) R.C.O. (2) H.P. Males. Salaries £150 p.a. and £100 p.a. respectively.

ST. BARTHOLOMEW'S HOSPITAL, E.C.—Surgeon.

ST. THOMAS'S HOSPITAL, S.E.—Visiting Anaesthetist.

SHEFFIELD: CHILDREN'S HOSPITAL.—H.S. (male, unmarried). Salary £100 p.a.

STOCKPORT INFIRMARY.—H.S. and C.O. (male). Salary £150 p.a.

STOKE-ON-TRENT: BURSLEM, HAYWOOD, AND TUNSTALL WAR MEMORIAL HOSPITAL.—(1) R.H.S. (2) Senior R.M.O. (male). (3) R.H.P. Salaries £175 p.a., £175 p.a., and £150 p.a. respectively.

STROUD GENERAL HOSPITAL.—R.M.O. Salary £150 p.a.

SURREY COUNTY COUNCIL.—J.A.R.M.O. at the County Sanatorium, Milford. Salary £350 p.a.

SUTHERLAND COUNTY COUNCIL.—Local M.O. for the Parish of Farr. Salary £200 p.a.

SWANSEA COUNTY BOROUGH.—A.M.O. (female). Salary £500-£25-£700 p.a.

SWANSEA GENERAL AND EYE HOSPITAL.—(1) H.P. (2) C.O. Males, unmarried. Salaries £150 p.a. and £150-£175 p.a. respectively.

TIVERTON AND DISTRICT HOSPITAL.—H.S. Salary £120 p.a.

WESTERN OPHTHALMIC HOSPITAL, Marylebone Road, W.—J.R.H.S. Salary £100 p.a.

WOLVERHAMPTON: ROYAL HOSPITAL.—H.P. (unmarried). Salary £125 p.a.

CERTIFYING FACTORY SURGEON.—The appointment at Banbury (Oxfordshire) is vacant. Applications to the Chief Inspector of Factories, Home Office, Whitehall, S.W.1, by May 5th.

BIRTHS, MARRIAGES, AND DEATHS

The charge for inserting announcements of Births, Marriages, and Deaths is 9s., which sum should be forwarded with the notice not later than the first post on Tuesday morning, in order to ensure insertion in the current issue.

BIRTH

LORD.—On April 15th, 1936, at Astoria Nursing Home, to Helen, wife of Dr. Herbert Lord, Colwyn Bay, a daughter.

MARRIAGES

BILLINGTON—BUNYAN.—On April 14th, at All Souls Church, Langham Place, London, Richard Willis, second son of Mr. and Mrs. Billington, Ellenhall, Staffs, to Ethel Mary, only daughter of Captain and Mrs. d'Arcy Bunyan, Portsmouth.

SHEPLEY—LUMSDEN.—On Tuesday, April 21st, at Farleigh Church, Surrey, by the Rev. Dr. Perry, William Hadfield Shepley, M.B., D.P.M., Senior Assistant Medical Officer, Croydon Mental Hospital, Warlingham, son of Mrs. Shepley and the late Eli Shepley of Furness Vale, near Stockport, to Hilda Amy, youngest daughter of Councillor and Mrs. H. G. Lumsden of "Royston," South Norwood Hill, London, S.E.25.

DEATHS

MACGREGOR.—On Saturday, April 18th, 1936, Elizabeth Bannerman, beloved wife of Dr. I. W. MacGregor, Glanmire, Broomy Hill, Hereford.

MORRIS.—John Ignatius Worgan Morris, on April 18th (suddenly), for twenty-five years Medical Superintendent of Kelling Sanatorium, Holt, Norfolk. Interment at Sheringham Cemetery, April 21st. (No flowers or mourning, at his special request, but donations may be sent to Kelling Sanatorium Patients' Recreation Fund, which was very dear to his heart.)

ROBERTS.—On April 17th, 1936, at 30, Princes Avenue, Liverpool, Mona Dew Roberts, M.B., B.S. (Univ. London), aged 57 years, daughter of the late Dr. John Roberts, Menai Bridge, formerly Physician at the Manchester Royal Infirmary.

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